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MINNEAPOLIS VA MEDICAL CENTER CONSTRUCTION PROPOSAL

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

APRIL 8, 1980

Printed for the use of the Committee on Veterans' Affairs

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MINNEAPOLIS VA MEDICAL CENTER CONSTRUCTION PROPOSAL

TUESDAY, APRIL 8, 1980

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The staff inquiry was held pursuant to notice, at 1 p.m., in the Russell Office Building.

Present: Jonathan R. Steinberg, Chief Counsel; Janice C. Orr, Molly Milligan, Edward Scott, Michael Buchanan, and John Pressly.

OPENING STATEMENT OF JONATHAN R. STEINBERG, CHIEF COUNSEL FOR THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Mr. STEINBERG. We would like to welcome everybody here today. My name is Jon Steinberg. I am Chief Counsel of this committee, and today's activity is being carried out as a result of a request by the Chairman to me to conduct an intensive review of the VA's proposed construction project in Minneapolis as part of this committee's exercise of its new responsibilties to engage in an authorization process for major construction projects approved by the President after October 1979.

As all of you know, that new responsibility was as a result of the enactment of Public Law 96-22 last June. Our purpose is not to be saying things to you today, but rather to hear things from all of you.

I am going to be very, very brief in what I have to say at the outset. Following my remarks, there will be a presentation, as I understand it, from the VA that Mr. Cralle will make with respect to this proposal.

It is going to be quite hot in the room today, and I would like to suggest that anybody, as the afternoon goes on, should feel free to take their jackets off or whatever would make them most comfortable.

I also think it would be very helpful if we could keep the smoking down to a very minimum in order to keep the heat down; and it would also help the reporter who is taking a transcript for us.

In order to facilitate keeping a transcript, would you each, when you speak at the outset, identify yourself so that she can be sure of who is speaking, and also give her a minute to pick up the train of thought.

At a certain point, we expect that we will be engaged in a roundtable discussion.

It is our hope that this kind of a process will be of assistance not only to the committee, but to the Minneapolis community, to the

Veterans' Administration Central Office and Minneapolis VA Medical Center personnel here, and to the organizations that have come to be with us from the Minneapolis area that are concerned with health planning and health services generally in that area; and, of course, to the veterans service organizations, that are represented to my left, who have a primary concern for the services that this entire construction project is really all about, the services for eligible veterans.

The last point I would make is that this committee is involved in the process now required in title 38 as a result of Public Law 96–22 as a novice in the area of authorizing construction programs.

This type of procedure is one which we thought would be a good way to try and educate ourselves and provide for appropriate information to flow back and forth to the other concerned parties.

Whether we will adopt this format in the future will depend on the results of this particular meeting.

Finally, I guess it is fair to say that this is the single biggest construction item proposed in the VA's fiscal year 1981 construction budget insofar as both budget authority and outlays in the forthcoming years are concerned, and we thought that this would be a good place to start an intensive review based on the new Public Law 96–22 responsibilities.

That's all I have to say. If you want to proceed now to make what I hope will be a presentation in the area of 10 minutes or so, 15 minutes perhaps. Let's not go too much beyond that so we have an opportunity for everybody to participate this afternoon.

We have name plates in front of everybody, and each of you has been given a list of the participants which is substantially correct, but which may be subject to last-minute changes.

Rather than go around and introduce everybody, we will trust that you can look at the list, see the signs that are posted, and if you have any questions about who is doing what, you can ask us and we will be glad to clarify it.

TESTIMONY OF MAURY S. CRALLE, JR., ASSISTANT DEPUTY ADMINISTRATOR FOR FINANCIAL MANAGEMENT AND CONSTRUCTION, VETERANS' ADMINISTRATION, ACCOMPANIED BY DR. HERBERT M. BAGANZ, ASSISTANT CHIEF MEDICAL DIRECTOR FOR PLANNING AND PROGRAM DEVELOPMENT, DEPARTMENT OF MEDICINE AND SURGERY; BROOKS MARTIN, HEALTH CARE FACILITIES SPECIALIST, OFFICE OF CONSTRUCTION; ROBERT E. COY, DEPUTY GENERAL COUNSEL; WILLIAM A. SALMOND, DEPUTY ASSISTANT ADMINISTRATOR FOR CONSTRUCTION; AND DANIEL COONEY, DIRECTOR OF VETERANS' ADMINISTRATION MEDICAL CENTER AT MINNEAPOLIS; ACCOMPANIED BY DR. RANDY PETZEL, CHIEF OF STAFF

Mr. CRALLE. Thank you very much. Good afternoon, Mr. Steinberg, ladies and gentlemen.

I would briefly say that the VA is pleased to be here today, and to explain the Minneapolis project to you, to respond to your concerns and questions.

We have a presentation which two particular gentlemen will give. We also have at the head table Dr. Petzel, Chief of Staff; Mr. Cooney, the Director; Dr. Baganz, and ACMD for Planning and Program Development. I am the Assistant Deputy Administrator for Financial Management and Construction, and Mr. Coy here is our Deputy General Counsel. Mr. Brooks Martin is the hospital facility specialist concerned with this particular hospital; and finally, Mr. Salmond is the Assistant Administrator for Construction at this time.

We want to be brief, but very informative. Dr. Baganz will open with a statement concerning the planning, and then Mr. Martin will give an audiovisual presentation to discuss the project itself.

I will turn it over to Dr. Baganz.

Dr. BAGANZ. Good afternoon, Mr. Steinberg, ladies and gentlemen. We are pleased to be here and on behalf of the chief medical director of the Department of Medicine and Surgery, I welcome this opportunity to present our views with respect to the critical need for replacing the Minneapolis VA Medical Center.

We are aware of and fully support section 5004(a) of title 38, United States Code, as amended by section 301(a), Public Law 96–22, and appreciate the importance of both the Senate and House Committees of Veterans' Affairs having an opportunity to review critically major projects in excess of $2 million prior to adopting a resolution approving such construction.

The intent of this presentation is to demonstrate the immediate need to replace the antiquated medical facility at the Minneapolis VAMC site with a modern health-care facility commensurate with the quality of care and the health-care mission of that medical center.

On April 4, 1980, we provided to Senator Cranston's office copies of a document entitled "An Overview, Replacement of the Veterans' Administration Medical Center, Minneapolis," in which the Department of Medicine and Surgery articulated the history, planning processes, major milestones, workload and other pertinent data relevant to identifying the need to replace the Minneapolis VA Medical Center.

This document demonstrates the urgent need and timely support through the fiscal year 1981 budget process to replace the VAMC, Minneapolis.

I would like briefly to review the overview document and answer any questions you may have relevant to the package as presented.

The Minneapolis VA Medical Center, which is located on 111 acres in the southern part of the Twin Cities of Minneapolis and St. Paul, is a classical representation of a number of medical facilities which the VA inherited in 1930. The oldest section of this medical center was activated in 1927, with a newer complex of 464 beds being constructed in 1953. This facility is presently operating 738 hospital beds, 40 percent of which are still located in the original six 1927 vintage buildings.

This tertiary care facility presently employs in excess of 2,500 people, and has an annual budget of approximately $70 million. The specialized medical services available include prosthetics and restoration clinics, orthotics laboratory, drug and alcohol programs, day hospital care, a hospital-based home care program and a dialysis center.

In addition, the hospital has a cardiac catheterization and pulmonary function laboratories, a respiratory care center, as well as three intensive care units.

In 1979, the surgical staff at this facility performed 109 open-heart procedures with cardiopulmonary bypasses. Although during the past 5 years the average daily census has decreased, the number of patients treated has remained constant.

They are presently operating at lengths of stay of 8.2 and 9.3 days, respectively, for acute medicine and surgery. Not unlike the other facilities in our system, their outpatient workload continues to grow and in fiscal year 1979 exceeded 200,000 visits.

The medical center has one of the largest education and training programs in the Veterans' Administration, ranking in the top 1 percent of all VA medical facilities. During fiscal year 1979, 1,525 students and residents were involved in training programs at the facility. The Minneapolis VAMC also has one of the largest research programs in the Veterans' Administration. For fiscal year 1981, an excess of $4 million has been budgeted for research, $3.8 million of this amount is for medical research alone.

Studies internal and external to the VA; as cited by outside experts in the field, have confirmed our judgment to replace the Minneapolis VAMC on a timely basis. The perceived need for replacement of the Minneapolis VA Medical Center, not unlike the number of our other health-care facilities, was visually identified a number of years ago.

However, the VA had neither the refined planning techniques, evaluation instruments, nor resources to support or proceed with accommodating this need. It was during 1972 that the Department of Medicine and Surgery made a major advancement toward establishing a planning process that would empirically identify construction needs. The intent is to make plans withstand critical review.

This planning tool was called the 5-year facility construction plan. Through this process, the VA Medical Center, Minneapolis, cited a number of major construction deficiencies required to meet their tertiary medical care mission.

These deficiencies were further underlined through the 5-year comprehensive health care planning process, the space and function deficiency identification survey, and finally, cited by an independent A. & E. firm contracted to develop a master plan.

The decision, oversimplified, was either to continue the fragmented "bandaid" approach through the nonrecurring maintenance and repair program or to move toward a major replacement of the facility.

In 1979, the decision was proposed by the department and supported by the agency and the Administration to replace the Minneapolis VAMC.

While we were aware of the current overbedded state of the Minneapolis metropolitan area hospital community, it is important to note that the Minneapolis health service area consists of seven counties, while the VA primary service area consists of 72 counties, clearly demonstrating the need for the VA to plan from a much broader perspective.

The replacement of our facility will not add beds to the area, but will simply provide the VA with a safe and functionally sound facility to continue supporting the tertiary care mission of this health-care center. The document previously provided you clearly delineates the specifics of this brief presentation.

We trust that information presented will without question aid you in assisting the members of the Senate Veterans' Affairs Committee to adopt a resolution under section 5004(a) of title 38, United States Code, to proceed immediately with the Minneapolis replacement project.

The agency's Office of Construction has compiled a series of, one, slides detailing the process by which the Department's determination of need was turned into a conceptualization and, two, photographs depicting the seriously deficient conditions presently existing at the Minneapolis VA Medical Center.

I would like to introduce Mr. Brooks Martin, health-care facilities specialist, from the Office of Construction, who will be making this presentation.

Mr. MARTIN. Members of the staff and guests, in order to abbreviate our presentation and hold the time down, I would like to follow up on what Dr. Baganz has indicated. Mainly he has spelled out, and primarily in the documents, presented detailed methodology by which the Veterans' Administration established the needs at the VA Medical Center in Minneapolis.

I would like to carry it forward from that point so as to acquaint you with the steps that we are taking from establishment of the needs to the development of a conceptual plan.

The Veterans' Administration Office of Construction receives a data package from D.M. & S. These are the items. [Slides] I would like you to look at these. I am going to move rather rapidly to save time.

These are the elements of information we receive from the Department of Medicine and Surgery, and it is on the basis of this that we move forward into developing what our physical needs will be.

The first activity undertaken is the physical facilities assessment study. This study takes a look at the existing site and all elements of the site, environment, transportation, geology, utilities, fire and safety, code compliance, and even major equipment evaluations.

This study is done by an independent group contracted out, and reports back to the VA.

In effect, we know the condition of each and every building. There are over 100 of them in Minneapolis, and we know what we have to work with, what our deficiencies are, what the positive aspects of the site are.

We then contract out to an independent architectural engineering consulting firm to develop a conceptual plan that will meet the needs as cited by D.M. & S., and take into consideration the data that was developed in the physical facilities assessment.

We develop three alternatives in our conceptual planning, and this is important. When we asked the architects and consultants to develop a complete comprehensive conceptual plan for major renovation with minor new construction if needed; and the inverse of that, minor renovation with major new construction; and then in all instances of our master planning we asked them to develop a total program for a total replacement facility. This is so we can draw cost comparisons, and through this study of cost comparisons we can come back to the Administrator of the Veterans' Administration with recommendations for his consideration.

In the case of Minneapolis, the total replacement, in affect, is a 90-percent replacement project, and we will explain that in a few minutes.

I'd like to point you to the site. At the very center of the site the high rise structure is building 43. This is the building that was constructed in 1950 and opened in 1953.

That entire site, down to the highways—you can see highways on two sides of it—is the site itself, and then across to the east of it is additional property, much of which has been deeded over to the State of Minnesota for the continuation of a freeway interchange and interconnector.

Notice the Minneapolis International Airport. Those of you can orient yourselves if you are familiar with the immediate area. You will notice to the north of us and to the west of us is strictly residential areas. The other borders are Mississippi and Minnesota Rivers.

In the lower right-hand corner you can again see the 1950 structure, and I would like to point out the ring of structures that were built in 1928 around the back. This is typical of many VA hospitals.

This is approximately where up to 50 percent of our patients were at one time. We have been bringing more of them—as we have cut beds we have brought them out there and the outpatient clinics have taken up the old buildings.

For relationship here, I would like to show you some distances from building 43 which you see to the new Federal building. That is roughly 1 mile.

Off to the right of the new Federal building, about 1¼ miles, is our fire station and our warehouse, and then our research buildings and our boiler plant.

At any rate, we are approximately 1 to 1½ to 2 miles away.

Incidentally, part of our outpatient clinic and some of our research facilities are in stables and headquarter buildings that were used by General Custer at Fort Snelling, and you will get the idea of the age of some of those.

I would like to point out one thing quickly to some of you who have been by the facility, and as we look at these slides. They have done an unusual job of landscaping, building maintenance, and interior decorating. One of our problems is the fact it's hard to describe the condition of these buildings because they look so well. The grounds are excellent. It is a site we want to keep. It's 111 acres, it's in an excellent location for us and for the veterans coming in, seeing that more than half of them approach through the freeway interchange, and about 20 percent of them come from the airport.

Most of the facility is made up of buildings that have long past code compliance and present significant fire and safety hazards.

You are looking at wood attics. I will move very quickly through just to give you an image. The buildings have been attached and connected by temporary interconnectors, quonset huts are continuously built. We are not looking at the same quonset huts. I would venture to say we may have as many as 50. They are all in use, some of them in patient service, some patient support.

Fire hazards are significant, structural defects are significant, and, of course, the separation. You could walk for miles in this facility going from one significant area to another.

One of the new structures is the educational building which is a salvageable temporary structure.

This building 49 was built in 1970 and accommodates research and the basement engineering shops. In the proposed conceptual plan it would be the animal research facility. Engineering would move out of it, and it would accommodate one-third of our research programs.

That's another view of the research building.

Now, moving to the interior, a great deal of money can be spent on renovation. It's almost impossible to bring these buidings into the fire and safety code compliance. There are narrow corridors and inadequate space. You will notice wall fans for ventilation. Ventilation is poor in these buildings.

These are not conditions that we want for our veterans. Patient privacy is literally nonexistent. In some of these pictures you will see we emphasize wheelchairs. I think very few people realize how many of our patients are handicapped, and its' absolutely impossible to correct all of the barriers to the handicapped in these old buildings.

In the coronary care unit you can see conditions are extremely crowded. When code blues are called, we literally have to pull a patient out of the next bed.

You will notice this is the recovery room. I believe there are 16 operating rooms. We have only four recovery positions.

This is one of the dialysis rooms. You can see the old buildings do no lend themselves to good observation, care, or ready access to the patient.

I think the best example of crowded conditions is in the laboratories. We have one of the largest laboratories in the VA systems here, and certainly one of the most sophisticated in the country, and you can see that the equipment is literally crowded on top of one another.

Dayrooms—this is rather typical of some of the areas for patients. Canteens aren't any more pleasant. I think it is important to note the long winter months in Minnesota, and the fact that the patients want to get out of the rooms. These are the kind of areas they are restricted to.

Now, in the conceptual plan itself—first let me say that the Administrator made a selection, and that selection was a total replacement with the exception of the regional medical education building which would remain, and the 1970 research building would remain. Next to it is the underground radiation therapy department and that would remain.

Ninety percent of the present facility would be replaced. Now, this is going through the comparison process that we mentioned earlier, and which we presented in detailed form for you.

The new structure would sit inside the central part of the site. It is a very compact structure, and it is a unique design in the hospital. It is four stories high, and we utilize the VA building system, and it would be roughly a 130-foot elevation, just slightly below where we are now.

We have height restrictions here because of proximity to the airport.

These are just some views of how the mass would look on the site. I wish we had more time to discuss this in greater detail, but perhaps questions later and we could get into it.

The wings you see, sticking out and facing you, are actually nursing units. There is roughly 240 beds on each floor. There are 725 beds, acute medical, surgical, psychiatric, neurology, and rehabilitation, and 120 nursing home beds.

The nursing home and rehabilitation are on the first floor, so we would have access to the outside from individual rooms. [Slide.] That's one of the typical nursing units except on the first floor, and there is a backup area, separate dining, and recreation.

Just for your reference [slide], this is the funding for the project, and this is the schedule. Now, we have given you some draft master plans, and I would add that they are draft. The master plan and conceptual planning was not scheduled for completion until the 15th of this month.

The architect quickly pulled together the master plan you see, and we have already changed this schedule to some extent. We have not had the time to verify the cost estimates which follow.

Basically, this is the schedule that the project is based on, and that the project is budgeted on at the present time.

I would like to turn it back to Dr. Baganz in case there are any questions. Thank you.

Dr. **Baganz**. Jonathan, this completes our presentation. We would be very pleased to answer any questions of you or your staff at this time.

Mr. **Steinberg**. I think it would be preferable if we would defer questions for a few moments and have some brief remarks from the other participants who are here this morning. I think they will have questions. You may have questions of them. We may have questions of all of you.

Why don't we, at this point, ask Mr. Dickler from the University of Minnesota if he would like to make a few brief remarks in terms of where the university is at this point in its process, the construction project, and what relationship he sees at this point between where the university is headed and where the VA would like to be headed.

TESTIMONY OF ROBERT DICKLER, SENIOR ASSOCIATE DIRECTOR, DEPARTMENT OF HEALTH SERVICES ADMINISTRATION, UNIVERSITY OF MINNESOTA

Mr. **Dickler**. Thank you, Mr. Steinberg.

My name is Robert Dickler. I am senior associate director of the University of Minnesota hospitals and clinics. I shall keep my remarks very brief.

First, let me comment that the relationship between the Minneapolis Veterans' Administration Hospital and the University of Minnesota, primarily the health sciences center, has been a very long and profitable one from our perspective.

The university and Minneapolis VA Hospital did establish one of the first dean's committee relationships back in the mid-1940's, and the Veterans' Administration hospital has been an intricate part of the education and research program of the university.

I think it would be fair to say that from the perspective of the academic units, it would be difficult to maintain the present scope and quality of their clinical teaching programs if the Veterans' Administration hospital was not available for that training.

In terms of relationships between the university and the Minneapolis VA Hospital, they are primarily in the academic areas. There are some relationships that exist between university hospitals and the Veterans' Administration hospital, but they are limited.

We do share some services including stereotaxic surgery, some gastroenterology diagnostic procedures, some laporoscopy procedures, and certain other specialty procedures.

We have worked closely over the last 10 years in cooperative arrangements and discussions to try and assure that duplication is kept to a minimum; and we continue to have those discussions and have been discussing with the representatives from the veterans' hospital over the past several months some possible areas of additional sharing which might be fruitful as part of our separate capital programs.

In terms of the University of Minnesota capital program, the university is contemplating the partial replacement and upgrading of the present university hospital complex.

By way of background, the University of Minnesota Hospital is approximately a 750-bed institution that has about 22,000 inpatient admissions, in excess of 200,000 patient-days, and in excess of 200,000 outpatient facilities.

Many of the facilities have problems very similar to those we just reviewed in terms of the Minneapolis Veterans' Administration Hospital. Portions of our facilities date back to 1911.

We are moving ahead to initiate a construction project which would replace approximately two-thirds of those beds, as well as some of the support service activities. We will continue to utilize almost all of the existing facilities which we have.

I think, Mr. Steinberg, I will limit my comments to those and respond to any questions you might have.

Mr. STEINBERG. Thank you. That's very helpful at this point.

I wonder if Mr. Mitchell from the Metropolitan Health Board would like to give us an idea of his concerns at this stage. Mr. Mitchell, could you tell us where the A-95 process is, what exactly the function of your organization is, which, as I understand it, carries out an HSA function for the seven-county area, and exactly where your organization's functions fits into this entire process, vis-a-vis both the proposed VA facility and the proposed university facility?

TESTIMONY OF MALCOLM MITCHELL, EXECUTIVE DIRECTOR, METROPOLITAN HEALTH BOARD, ST. PAUL, MINNESOTA

Mr. MITCHELL. Thank you. I will try to do that.

My name is Malcolm Mitchell. I am the director of the Metropolitan Health Board which is part of the metropolitan council in St. Paul, Minn.

The council, together with the Metropolitan Health Board, is the federally designated health system agency for the seven-county metropolitan area which does include the two central cities of Minneapolis and St. Paul.

The metropolitan council is a public regional planning organization that is created through specific State legislation which was passed in

1966, and is responsible for overall planning for the social economic physical aspects of the seven-county metropolitan area.

As such, the council is also designated as the local clearing house under the Office of Management and Budget, A–95, and the Inter-Governmental Cooperation Act of 1968.

As we have been talking, the Minneapolis VA Hospital is located within that seven-county area. The metropolitan council and the health board have been actively engaged in regional health planning since 1970. At that time the first health board was formed. At that time it was formed as the area-wide comprehensive health planning agency under previous Federal legislation known as the Comprehensive Health Planning Act of 1966.

The first health plan was established and it was adopted in March 1974. We have continued to revise and update that plan since, particularly, it relates to the health system agency functions which we were designated to perform in 1966.

We have been, through the health planning process and based on Federal mandates, passing to do a better job of hospital and long-range planning, to cut unneeded services and beds, and to make sure that those services that are needed and new expansions and new projects are consistent with a reasonable justification and need for the area.

We have had a long and considerable process with most of the hospitals in the area, and have developed a joint and voluntary long-range hospital planning process involving all of the hospitals in the seven-county area.

The veterans' hospital was asked to participate early in the process. It was not able to submit a long-range plan as other hospitals in the area have done, and we were disappointed with that.

We view the opportunity to work with each of the area hospitals as being invaluable. It provides us an understanding of the individual goals of each institution, and their impact upon the entire metropolitan area hospital system.

We believe that the Minneapolis Veterans' Hospital is a central part of the community; that approximately 40 to 50 percent of its patients do originate from within this seven-county area, and there is no doubt that it does have a significant impact upon the hospital system within the seven-county area.

It is the health board's and the council's belief that all hospitals need to participate in that planning process, and clearly the veterans should be part of that planning process.

We understand the needs of the veterans, and look at particularly the elderly veteran, some of the disadvantaged veterans who are using the facility, and take those factors into consideration as well as those persons who are served from outside the seven-county metropolitan area as we do in looking at the university project which we do review specifically under the State certificate law since it is licensed within the State of Minnesota.

In early February we received a letter from the Veterans' Administration asking us to conduct the A–95 review process. We have begun that process.

We have appointed from the Health System Agency Board, the health board, a 10-member Project Review Committee. That Project

Review Committee is meeting every Wednesday. It will meet throughout April, and we would intend by April 30, to hold a public hearing on the proposed project from the Veterans' Administration.

We will be reviewing under the A–95 process. The specific process we are using is similar in nature to the certificate-of-need process we use with all the other hospitals within the seven-county area; and we believe that the issues are essentially the same; the information is the same. We need to consider the uniqueness, the role of the VA, but the process of performing that review is essentially similar.

We have anticipated that the Project Review Committee will make preliminary recommendations and findings of fact around April 23, so that they are available to the veterans' hospital at the time the public hearing is held on April 30.

Following the public hearing the health board would make formal findings and recommendations and submit them on to the metropolitan council, which is the regional planning organization for the area; to the VA hospital; to you; your staff; to other persons like the Minnesota Congressional Delegation.

To date, one handicap in the review has been the lack of specific detailed information. We did receive yesterday the major document entitled "Overview." I have not had a chance to look at that document in depth.

The information which we are receiving here will be fed into the process as well, and we will look at all that information, including the information which was distributed by representatives of the VA hospital at two previous Project Review Committee meetings which have been held; and we are looking forward to receiving any other pieces of information that are pertinent.

We did send a request to Mr. Cooney, the administrator, outlining the type of information we felt was necessary to conduct the review, and we have received most of that. There are still some pieces, I believe, and maybe they are in the document received yesterday. I am not sure at this point.

Essentially the health board is looking at four major areas.

First, the role and relationship of the Minneapolis VA Hospital in the VA system, and with the local community. As I indicated previously, we wanted to recognize the fact—I think it was mentioned earlier—that the VA does serve 72 counties. We are looking at seven counties.

The magnitude of the inmigration, the magnitude of the use of the Minneapolis VA Hospital as a tertiary resource for persons outside of the metro area will clearly be looked at within the review process as well as it will be looked at in terms of the University of Minnesota project which we also review.

Second, we look at the need for the hospital and nursing home in terms of its size and the scope of services to be offered. We will try to look at the best available demographic data and other statistical information, and it will include such things as length of stay and projections of need based on veteran population both in the region and throughout the upper Midwest.

We will want to look at the physical and economical impact of the replacement, and how the figures were arrived at. We will also want to look at the present and the potential future relationships between the Minneapolis VA Hospital and particularly the University of Minnesota hospitals, and possibly other community hospitals that may be appropriate.

I think within that we will be looking again, as Mr. Dickler indicated, at the medical education programs where there is a great deal of sharing, at some of the overlap in medical staff, and other kinds of specialty services such as open heart surgery, radiation therapy, mental health, and other geriatric care programs.

We believe that we will do everything possible to conduct an objective, fair analysis of the proposed project; an analysis which recognize the needs of the veteran population for high quality care and the role the Minneapolis Veterans' Hospital plays in the upper Midwest region.

At the same time, we must look at the impact on the metropolitan area. We must consider the fact that we do have in the metropolitan area an excess in capacity of hospital services in the area; and we do need to consolidate, to merge, to share some specialized services wherever possible to help contain the rise in health-care cost.

We have established goals for the region within the metropolitan Minneapolis area at reducing 2,000 licensed beds and consolidating specialized services.

We view the review of the Minneapolis VA process as a major review of the health board, and we would look particularly at questions of size and possible consolidation of highly specialized medical services; particularly potentially with places like the University of Minnesota.

We would want to work with both the university and the VA hospital to discuss those further prior to making any recommendations by the end of April.

We believe that the project needs to be coordinated. We urge that your committee and staff consider our recommendations which are intended to be made by the end of May, or I should say the end of April, early May, and provide those considerations as considerations for your decision in the process.

We are available as health board staff, as health board members to provide information, to provide data, any technical assistance you would like. We also assist the local VA hospital in their planning as we can, and in the review process to outline that process for you.

I will end my formal comments at that point and be available for any questions.

Mr. Steinberg. Could I ask you at this point if you would indicate a timetable for your review of the medical school construction project?

Mr. Mitchell. Indications are—maybe Mr. Dickler can also clarify the situation from the university standpoint. We have had at least a couple of meetings with the board of trustees and administration of the University of Minnesota hospitals as part of our ongoing long-range planning process with all hospitals.

In those meetings, it has been indicated to us that we would receive a formal application under the State certificate-of-need legislation sometime in August, or early September. I understand there may be some moving up of that date. Mr. Dickler can comment on that.

So, in the meantime, we are also continuing to meet on a more or less informal process with the committee of the health board, and with representatives from the university hospitals to talk about what it is that is being planned.

We have a fair idea and a lot of information already about what is being proposed at the university. The formal review process under the State legislation would begin probably in August or September.

Mr. **Steinberg.** How long will that take?

Mr. **Mitchell.** That will take approximately 90 days for the entire State process. That is a State law, and we have at Metropolitan Health Board Council level approximately 55 days to do the review at that level. We would make our recommendations to the State and give time for their final decision.

Mr. **Steinberg.** Do you have any comment on the timetable issue?

Mr. **Dickler.** No. That's essentially the same. We anticipate submitting our application in late August, early September at this time.

Mr. **Steinberg.** Thank you.

I would like to ask the veterans organizations that are represented here today, and we have four of them, starting with the Legion, if they would like to make some brief opening comments.

We very much welcome hearing from those of you who have come in from the field.

Phil, do you want to start on behalf of the Legion?

TESTIMONY OF PHILIP RIGGIN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION, ACCOMPANIED BY MICHAS M. OHNSTAD, DIRECTOR OF REHABILITATION, DEPARTMENT OF MINNESOTA

Mr. **Riggin.** I would like to say on behalf of the national organization——

Mr. **Steinberg.** This is Phil Riggin from the American Legion. Please try to identify yourselves as much as possible for the record.

Mr. **Riggin.** I am deputy director, National Legislative Commission of the American Legion. In my position representing the National Organization of the American Legion, I would like to say we traditionally have agreed with the VA's decision to replace or build medical facilities. We find ourselves again in agreement with VA's decision on this particular facility, that it should be totally replaced rather than remodeled, and that its current site is the most desirable.

I have with me Michas Ohnstad who is the director of rehabilitation for the American Legion in the State of Minnesota who represents, of course, more specifically, the people who would be affected by this.

I would like to turn the matter to Michas for just 2 minutes of some specific comments that he has at this particular time.

Mr. **Ohnstad.** Thank you.

I am Michas Ohnstad, the director of rehabilitation for the American Legion, Department of Minnesota. I guess I could sum up my comments in two comments. One, that we are hoping that the facility will be completely rebuilt and, second, we believe that the present site is an ideal site.

I would like to point out some of the reasons and I am working directly in proximity to the building. I work at the Federal Building in the claims office. This is very important to have access to the veterans who are in the hospital, and for the veterans in the hospitals to have access to the VA center.

One of the important functions that is performed by all of the service organizations is the volunteer function. This is extremely important to the ongoing work in the hospital. We have reason to believe that the present site offers them better access to that facility so they can come and perform their volunteering efforts.

I emphasize that, because there are literally hundreds of volunteers who literally give hundreds of hours, thousands of hours, to the hospital and to the hospitalized veterans there. Anything that can enhance their possibilities of service would certainly be in favor of the present site.

I would also like to draw attention to all of you the importance of the proximity of the present property to the VA center. The patients at the VA hospital frequently have a need to be in personal contact with the various VA offices in the Federal Building.

It was pointed out earlier the close proximity. The facilities are so close now that it is practically within walking distance for those veterans who may be able to do that.

This is very significant for a veteran who may not be able to tolerate driving long distances from another site. I think another aspect that I would like to point out that the geographic factor is of good value to the various veterans organizations who have claims offices in the Federal Building and Fort Snelling, such as the VFW, the American Legion, and Disabled American Veterans as well as the American Red Cross, and certainly the VA itself, all of which provide claim service.

The American Legion of the Department of Minnesota has a full-time hospital representative who is frequently called upon to bring medical information, on very short notice, to the claims representatives at the Fort Snelling Federal Building.

The VFW and the DAV have staff members from their claims offices which regularly meet with the veteran claimants at the VA medical center.

This vital service would be hampered if the facility were to be built at another location.

I think we need to bear in mind, too, which has already been pointed out, that the VA hospital is not just a local hospital. It is, in fact, a regional hospital covering a number of States and counties in its attachment area.

I know from personal experience that a number of occasions The American Legion, and I am sure the other service organizations as well, have occasion to meet veterans or their families bringing them to and from the Twin Cities International Airport and returning them to the airport upon transfer or discharge.

This is a good service to the veterans and their families since the airport is also very close.

I think another item that supports our hope that it will be built new and at the present site is its proximity to the Minnesota Veterans

Home which has a close working relationship with the hospital as well.

So, in summary I would like to say we of the American Legion would like to see the entire hospital built new and on the present site.

Mr. STEINBERG. Thank you very much. That was very helpful, and it's always valuable to us to have the local perspective on any decision of this magnitude.

Don, would you like to go ahead for the Veterans of Foreign Wars?

TESTIMONY OF DONALD H. SCHWAB, LEGISLATIVE DIRECTOR OF THE VETERANS OF FOREIGN WARS, ACCOMPANIED BY ARCHIE PAVEK, MINNESOTA STATE COMMANDER, DONALD MILLER, COMMISSIONER OF MINNESOTA DEPARTMENT OF VETERANS' AFFAIRS, AND JOHN O'NEILL, ADJUTANT QUARTERMASTER FROM MINNESOTA

Mr. SCHWAB. I am Don Schwab. I am the legislative director of the Veterans of Foreign Wars, and accompanying me today is our Minnesota State commander, Archie Pavek of the VFW. We have our VFW adjutant quartermaster from Minnesota, John O'Neill, and also the commissioner of the Department of Veterans' Affairs, Donald Miller.

Jon, I would like to submit for the record hospital surveys made by one of our field representatives of the Minneapolis facility in 1975 and 1978, and the VA's responses thereto.

[The surveys previously referred to follow:]

VFW VETERANS OF FOREIGN WARS OF THE UNITED STATES

NATIONAL VETERANS SERVICE

Office of Director

September 8, 1975

Dr. John D. Chase
Chief Medical Director
Department of Medicine & Surgery
Veterans Administration
Washington, D.C. 20420

Dear Dr. Chase:

I am forwarding herewith copies of a report of survey of the Veterans Administration Hospital, Minneapolis, Minnesota, conducted by Robert O. Wikoff of our staff.

You are advised that the Hospital Director is being furnished a copy of this report.

A response at your convenience will be appreciated.

Sincerely,

Robert L. Ashworth

Robert L. Ashworth
Director

RLA/jge

Enclosures

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
REPORT OF SURVEY OF VA HOSPITAL

LOCATION	Minneapolis VA Hospital 54th St. & 48th Ave. So., Mpls, MN	NAME	R. O. Wikoff, Field Representative
DATE	(as of) 6-30-75	DOCTORS	91 (+2 FTT)
CLASSIFICATION	General Medicine & Surgery	DOCTORS - PART TIME	17
DIRECTOR	Arthur J. Klippen, M.D.	RESIDENTS	154
CHIEF OF STAFF	A. Falk, M.D.	DENTISTS	6
RATED BED CAPACITY	863	NURSES	283 + 8 FTT + 10 nurse anesthetists
OPERATING BEDS	863	NURSES - PART TIME	39
PLANNED ADC	705	NURSING ASSISTANTS	112
ACTUAL ADC	693	MAINTENANCE & HOUSEKEEPING	267
TOTAL PATIENTS THIS DATE	695	ADMINISTRATIVE	427
NSC/OPT PATIENTS THIS DATE	8,409 7-18-75	OTHERS	701
TURNOVER	182.9%	TOTAL PERSONNEL	2248
APPLICATIONS PENDING	0	CONSULTANTS & ATTENDINGS	287
*NSC WAITING LIST AS OF (DATE)	7-1-75 - 0	CONSULTANT VISITS LAST QTR	1,355
NSC WAITING LIST THIS DATE	0	FY INPATIENT BUDGET	(FY 1976) $37,951,500
SCHEDULED FOR ADMISSION	87	FY OUTPATIENT BUDGET	(FY 1976) $8,330,900
APPLICATIONS REJECTED LAST QTR	695	RESEARCH FUNDS	(FY 1976) $3,100,600
AVERAGE LENGTH OF PATIENT STAY	15 days	RESEARCH EQUIPMENT	(FY 1976) None
COST PER PATIENT DAY	(FY 1975) $107.47	REPLACEMENT EQUIPMENT CURRENT FY	$77,662

*Waiting list one year prior to date of this survey

OUTPATIENT CLINIC

EXAMINATION REQUESTS LAST QUARTER

A. PRIORITY (AT ONCE) 1088
B. REVIEW AND ROUTINE FUTURE 520
C. AUDIOLOGY CLINIC CASES 131

STAFF

A. DOCTORS (FULL TIME) 10
B. DOCTORS (PART TIME) 8
C. NURSES 5
D. DENTISTS 0
E. OTHER 135

EXAMINATIONS PROCESSED LAST QUARTER

A. RETURNED TO ADJ. 1651
B. COMPLETED 1471
C. CANCELLED 180
D. NO. OF REPORTS RETURNED TO MEDICAL AS INADEQUATE 17

CLINIC TREATMENTS LAST QUARTER 15,180
FEE BASIS TREATMENTS LAST QUARTER 11,609

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
REPORT OF SURVEY OF VA HOSPITAL

Minneapolis, Minnesota

1. INTRODUCTORY COMMENTS:

This hospital was constructed and open for business in 1926. The latest building was constructed and opened in 1972 which is the admissions building. The admissions building was designed to carry two full stories, however, it ended up as a one-story structure.

For all practical purposes, there is remaining, 171 acres of land situated adjacent to old Ft. Snelling. A considerable amount of land has been surplused to state agencies and the old Fort is currently being restored for historical purposes. The Outpatient Clinic is still located in one of the old buildings which is now state owned and is scheduled for restoration and conceivably could be taken over by the State of Minnesota in a moments notice. Should this happen, the Veterans Administration would have to relocate the Outpatient Clinic which, incidentally, should have been done many years ago.

The Outpatient Clinic is under the directorship of Dr. Klippen and is located about one and a half miles from the hospital. This is not an ideal situation from a management standpoint. The clinic should be located at the hospital not only for management purposes but for the purposes of rendering better medical services to the veterans when reporting for either examination or treatment purposes. There are many more medical services available at the hospital as opposed to the limited services at the Outpatient Clinic. It is a well known fact that the General Services Administration is the biggest land grabber in the world. In view of this agencies well known surveys of Government owned land and demands for excessive land, I would difinitely oppose any suggestions or demands by the General Services Administration to surplus any more land at the Ft. Snelling installation. The reason for this statement is that, as time goes by, a new replacement hospital will have to be built and the land should be preserved for this eventual purpose. Presently there is a need for additional buildings which will be found later in this report.

2. CONFERENCE WITH THE DIRECTOR:

When I arrived at this station, I was greeted by Dr. Klippen, Director of the Hospital and Dr. Falk, Chief of Staff. Dr. Klippen has been designated as the Medical Director of District #19. Funding for this current fiscal year appears to be much better than it has been in the past, in fact, Dr. Klippen informed me that as a result of the presidential survey, staffing has been increased by 39 additional employees. The core staffing ratio is now 1.7 to 1. The hospital is currently affiliated with the University of Minnesota School of Medicine. Dr. Klippen stated that this is a very good affiliation and the University does not make demands upon the Veterans Administration to further the interest of the Medical School. In fact, I am of the opinion that since Dr. Klippen is a very strong Director and there is no way the University of Minnesota Medical School could ever gain control in the operation of the hospital. I was informed that pressure has been mounting and is continuing to mount to build a replacement hospital on the campus of the University of Minnesota Medical School. This of course, would be a disastrous move in my opinion, inasmuch as there is available, enough land in order to construct a replacement hospital at the present site. Dr. Klippen informed me that all of the physicians on the staff are board certified. Since the survey in 1968, many new programs have been initiated. These consist of Epilepsy Treatment Program, Alcohol Treatment Unit, Electron Microscopy Unit, Hemodialysis Center, Home Dialysis Center, a Drug Treatment inpatient as well as outpatient unit, Hospital Based Home Care Program, Medical Intensive Care Unit, Coronary Intensive Care Unit, Nuclear Medicine, Renal Transplant Center and Stereoptactic Surgery. Dr. Klippen feels that the most important item needed at this time is the construction of an Ambulatory Care Unit. This should be accomplished by adding a second story onto the admissions building. The second most important thing is the construction of a complete new pharmacy building.

3. SPACE DEFICIENCIES:

a. Wards: In making a visual inspection of all ward areas, congestion in all hallways by excessive equipment being stored is existent. Space is just not available to have a storage area for carts, guerney's, wheelchairs and other items.

b. Pharmacy: The pharmacy is presently located in a make shift building and a quonset hut which is not large enough to accommodate all the needs of the pharmacy. In addition to this, the pharmacy should have additional equipment installed such as automatic dispensing units and a new pharmacy building as previously indicated.

c. Laboratory: The laboratory is currently being increased and here again, space is at a premium. Storage is in hallways and leaves an appearance of a very untidy situation.

d. Outpatient Service: Currently the Outpatient Clinic is located approximately one and a half miles from the main hospital activities and this situation should be eliminated at the earliest possible date by the construction of an additional story onto the admissions building. This would consolidate the operation of the Outpatient Clinic into the hospital setting which would be an ideal situation.

e. Additional Space Deficiencies: Exist in the outlying buildings and it is suggested that a new clinical building be constructed in order to relieve this congestion.

f. Canteen: Cafeteria and Retail Sales is in need of renovation and enlargement. The canteen cafeteria is very poorly laid out and space in both the cafeteria as well as the retail sales area is quite small and very limited.

4. FIRE AND SAFETY:

A number of deficiencies at the present, however, plans and requests for funding have been made to Central Office in order to correct all deficiencies. This station has its own Fire Department which is located on station and within approximately one mile of the main hospital building. Presently, an on sight survey is in progress. It will cost approximately two million dollars to alleviate the fire and safety deficiencies in existence. A private architectural firm is now in the process of drawing plans which will include sprinkler systems for various patient areas. As I understand it, this will also include additional fire exits at the end of the buildings which apparently do not meet the EPA standards.

5. EQUIPMENT:

Upgrading of building services equipment is an ongoing thing and at the moment, there are no deficiencies in any of the equipment with the exception of possibly one elevator which is to be converted to a fire resistant type elevator. The boiler plant was scheduled for replacement in the year 1975 and it is assumed that a new plant will be authorized. This plant should be constructed close to the hospital itself rather than have the plant located over a mile away. According to the Engineering Officer, the steam run from the present boiler plant has a loss equivalent to that which could be used for the heating of one entire building. It is also suggested that at the time the new boiler plant is constructed, consideration be given to placing equipment of adequate size and capacity in order to utilize the same boiler plant if and when central air conditioning is authorized for this station.

6. UTILITIES:

All utilities are furnished by commercial sources. There are no deficiencies in any of the utilities being supplied this station. This station does not have central air conditioning and this should be considered and authorized within the near future. The only air conditioning existing in the hospital is now spotted by window units located here and there.

7. STAFFING DEFICIENCIES AND RELATED PROBLEMS:

Even though staffing has been increased by some 39 positions in the last twelve months, there is still deficiencies in many areas. Dr. Klippen is well aware of the staffing deficiencies and I am sure that Central Office has been apprised of the situation.

8. Other areas in this hospital which were surveyed include Dietetics, Voluntary Service, Building Management, Rehabilitation Medicine Service, Library and Chaplaincy Service. All of these services appear to be very adequate, however, space deficiencies exist in many of the departments.

9. SUMMARY:

This report very briefly gives a picture of the existing problems in space deficiencies. However, considering patient care in buildings scattered on 171 acres and trying to fit modern treatment activities into buildings which were first opened in 1926, it is certainly not practical. In view of this, Central Office should immediately consider building a new high rise clinical building which would also house patients now located in the outlying four buildings. Also the construction of a new pharmacy building should be considered and implemented at the earliest possible date. Additional space is also definitely needed in the ambulatory care area and the Outpatient Clinic should be moved to the hospital setting at the earliest possible date.

10. FINDINGS AND RECOMMENDATIONS:

1. A new clinic building is vitally needed large enough to accommodate the placement of patients within the new structure thereby eliminating the outlying buildings.
2. A new pharmacy is vitally needed and should be the number two or number one priority at this station.
3. Automatic dispensing machines should also be installed in the pharmacy immediately.
4. The laundry needs modernization with a separate soiled linen room and new pass through washer extractor machines installed.
5. Complete central air conditioning is very badly needed.
6. Expansion of the admitting building is needed and a second story to this building should be authorized immediately.
7. Funds to adequately take care of fire and safety, such as construction of additional fire escapes and automatic sprinklers.
8. A new boiler plant should be constructed adjacent to the hospital and should also at the same time include sufficient and adequate size equipment to take care of the future air conditioning.
9. Centralized scheduling should be implemented at once.
10. Additional staffing is vitally needed in many areas of the hospital for direct patient care as spelled out in the presidential report.

11. EXIT INTERVIEW WITH THE DIRECTOR:

Upon departing from this station, all of the above mentioned recommendations were outlined to Dr. Klippen and Dr. Falk, Chief of Staff. Both Dr. Klippen and Dr. Falk agreed that all of the recommendations are vitally needed. Dr. Klippen stated that Central Office has been aware of the many deficiencies at this station for many years. I would also like to state at this point that while going completely through this hospital and interviewing many of the individuals on Dr. Klippen's staff, I found them to be very cooperative and extremely interested in patient care. I thanked Dr. Klippen for his splendid cooperation and asked him to convey my thanks and appreciation to his staff for their cooperation.

Robert O. Wikoff
Field Representative

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

DEC 10 1975

IN REPLY REFER TO: 10C1B

Mr. Robert L. Ashworth
Director, National Veterans Service
Veterans of Foreign Wars of the United States
200 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Ashworth:

I am pleased to reply to your letter of September 8, and to the recommendations contained in the report of survey conducted by Mr. Robert O. Wikoff at Veterans Administration Hospital, Minneapolis, Minnesota.

> Recommendations 1, 2, 5: New construction and modernization projects are included in the hospital's comprehensive facility plans. As our resources and priorities permit, these projects will be programmed accordingly.
>
> Recommendation 3: Although we agree that it would be desirable to have automatic dispensing machines in the pharmacy, we are unable to justify the cost of renovating the existing buildings. When the planned facilities are constructed, automatic equipment will be included.
>
> Recommendation 4: A review of laundry operations at Minneapolis is planned by Central Office Building Management Service with the objective of planning and recommending a complete processing system.
>
> Recommendation 6: The addition of a second story to the administration building is being evaluated to ascertain if it would eliminate the outpatient problem.
>
> Recommendation 7: A major construction project has been approved and funded for FY 1976 to construct additional dead-end corridor stairs. Additional sprinklers are also being funded in FY 1976.
>
> Recommendation 8: We anticipate that the boiler plant will be relocated and consideration will be given to furnish adequate facilities for a future air conditioning project.
>
> Recommendation 9: We agree that a centralized scheduling system should be implemented. The development and implementation of an effective scheduling system is now receiving the attention of the hospital's staff.

Show veteran's full name, VA file number, and social security number on all correspondence.

Recommendation 10: Funds for 55 additional FTE were provided in FY 1976 to improve the facility's core staffing ratio and to increase staffing for outpatient and special medical programs. Additional increases will be considered as resources permit.

We wish to thank Mr. Wikoff for his visit and thorough survey, and we appreciate the efforts of the Veterans of Foreign Wars of the United States in helping the Veterans Administration to maintain high standards in the facilities which provide medical care to veterans.

Sincerely yours,

John D. Chase

JOHN D. CHASE, M.D.
Chief Medical Director

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

DEC 15 1975

IN REPLY REFER TO: 10C18

Mr. Robert L. Ashworth
Director, National Veterans Service
Veterans of Foreign Wars of the United States
200 Maryland Avenue, N. E.
Washington, D. C. 20002

Dear Mr. Ashworth:

Thank you for your letter of September 15, and the copies of the report of survey of the Veterans Administration Hospital, St. Cloud, Minnesota, conducted by Mr. Robert O. Wikoff.

Our response to the recommendations contained in the report follows:

> Recommendation No. 1: Both ambulatory care and service connected outpatient visits are scheduled through a centralized scheduling clerk. The few non-scheduled visits to laboratory and x-ray will be eliminated by January 1, 1976, when these visits will be incorporated into the facility's centralized scheduling.
>
> Recommendation Nos. 2,3,8: Although we recognize the merits of these recommendations, we must consider the needs of our entire medical care system and establish our priorities and distribute resources accordingly. We will consider these construction projects as funds become available.
>
> Recommendation No. 4: One of the goals of the Department of Medicine and Surgery is to air condition all outpatient care facilities. However, those located in areas where climatic conditions are most severe receive top priority. Obviously, those situated in the north-central area do not fall within the high priority category.
>
> Recommendation No. 5: Only three buildings lack enclosed porches. One building will be enclosed in FY 1976, and the remaining two will be programmed in early budget years.
>
> Recommendation No. 6: The Department of Medicine and Surgery is conducting an evaluation study of the unit dose system. When the results of this study become available, we will determine future conversions of our health care facilities to the unit dose system.

Show veteran's full name, VA file number, and social security number on all correspondence.

Recommendation No. 7: Four housekeeping aids are now assigned to Building 2, one on each floor. Building 9, the Resocialization Center, remains a self-care building because the professional staff considers it of therapeutic value for the patients in this building to be responsible for its maintenance. Building Managment provides some monthly maintenance as well as periodic cleaning.

We appreciate Mr. Wikoff's visit to St. Cloud and his helpful suggestions for improvement of this facility.

Sincerely yours,

JOHN D. CHASE, M.D.
Chief Medical Director

VFW
VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
Office of Director

May 19, 1978

John D. Chase, M.D.
Chief Medical Director (10)
Department of Medicine and Surgery
Veterans Administration
Washington, D.C. 20420

Dear Dr. Chase:

I am forwarding herewith copies of a report of survey of the Veterans Administration Hospital, Minneapolis, Minnesota, conducted by R.O. Wikoff of our staff.

You are advised that the Hospital Director is being furnished a copy of this report.

A response at your convenience will be appreciated.

Sincerely,

Robert L. Ashworth
ROBERT L. ASHWORTH
Director

RLA/fvm

Enclosures

V.F.W. MEMORIAL BUILDING • 200 MARYLAND AVENUE, N.E. • WASHINGTON, D.C. 20002

VETERANS OF FOREIGN WARS OF THE UNITED STATES
NATIONAL VETERANS SERVICE
REPORT OF SURVEY OF VA HOSPITAL
STATISTICAL SHEET

DATE April 3, 1978	FIELD REPRESENTATIVE R.O. Wibell
LOCATION Minneapolis VA Hospital	TOTAL FULL-TIME EMPLOYEES 1990
CLASSIFICATION GM & S	STAFF PHYSICIANS 104 fulltime
MEDICAL SCHOOL AFFILIATION U. of MN	PART-TIME PHYSICIANS 35
HOSPITAL DIRECTOR Daniel E. Cooney	CONSULTANTS 302
CHIEF OF STAFF Dr. Raymond Jacobson	CONSULTANT VISITS LAST QUARTER 1,286
RATED BED CAPACITY 862	DENTISTS 5 fulltime
OPERATING BEDS 862	RESIDENTS 208
PLANNED ADC, CURRENT FY 644	REGISTERED NURSES 330 fulltime
ACTUAL ADC THIS DATE 633	LICENSED PRACTICAL NURSES 68 fulltime
ACTUAL ADC, ONE YEAR AGO 635	NURSING ASSISTANTS 89
TOTAL PATIENTS THIS DATE 613	PART-TIME--RN'S 66 LPN'S 18 NA'S 9
NON-VETERAN PATIENTS THIS DATE 8	BUILDING MANAGEMENT EMPLOYEES 127 fulltime
BED OCCUPANCY RATE 73.0	ADMINISTRATIVE EMPLOYEES 392 fulltime
VACANT BEDS 249	STAFFING RATIO (SPECIFY CORE, ETC) 1.95
PATIENT TURNOVER 255.3	CURRENT FY INPATIENT BUDGET $ 37,253,000
AVERAGE LENGTH PATIENT STAY 12.06	PREVIOUS FY INPATIENT BUDGET $34,387,000
APPLICATIONS PENDING 95	CURRENT FY OUTPATIENT BUDGET $12,388,000
NSC WAITING LIST THIS DATE 0	PREVIOUS FY OUTPATIENT BUDGET $11,834,000
NSC WAITING LIST ONE YR AGO 0	CURRENT FY RESEARCH BUDGET $ 3,876,022
SCHEDULED FOR ADMISSION 23	MAJOR CONSTRUCTIONS FUNDS FY $ 322,200
CURRENT REJECTION RATE 2%	COST PER PATIENT DAY $ 160.00

OUTPATIENT CLINIC

VETERAN POPULATION AREA OF JURISDICTION 530,363 TOTAL STAFF VISITS FY TO DATE 101,961
OPT-NSC PATIENTS THIS DATE 55,836 PREV FY 91,388 STAFF VISITS FUNDED FOR FY 190,242
OPT-SC PATIENTS THIS DATE 23,024 PREV FY 58,319 STAFF VISITS PREVIOUS FY 204,728
AMBULATORY CARE PATIENTS THIS DATE 1387 PREV FY 20374 AMBULATORY CARE VISITS FY TO DATE 12,123
COMP & PEN EXAMS COMPLETED FY TO DATE 2027 PREV FY 4670 CURRENT FISCAL YEAR 24,500
FEE BASIS COMP & PEN EXAM COMPLETED FY TO DATE 782 FEE BASIS TREATMENT CURRENT YEAR 38,663
FEE BASIS COMP & PEN EXAM COMPLETED PREV YR 1479 1 FY

NOTE: INCLUDE STATISTICS FOR DOMICILIARY, NHCU WHERE APPLICABLE.

ABBREVIATIONS:

ADC- Average Daily Patient Census	COMP & PEN- Compensation & Pension
FY - Fiscal Year	RN'S- Registered Nurses
NSC- Non-service Connected	LPN'S- Licensed Practical Nurses
SC - Service Connected	NA'S- Nursing Assistants

VETERANS OF FOREIGN WARS OF THE UNITED STATES
REPORT OF SURVEY OF VA HOSPITAL
MINNEAPOLIS, MN
April 3, 1978

1. INTRODUCTORY

I met with Mr. Daniel E. Cooney, Director, and Mr. Walton H. Bonner, Assistant Director, on Monday afternoon. I was informed that this hospital would lose 64 beds under the current bed reduction program which means the closing of two wards. In addition, between 32 and 38 employees will have to be terminated by September 30, 1978 in order to conserve $698,000. Staffing is apparently adequate in all areas except the police force and it is felt that this department needs an additional eleven employees in order to have a full three-shift force on duty 24 hours a day, seven days a week. Space is very critical in all areas-bedrooms, wards, and clinical areas. These problems are well documented by a recent study the Veterans Administration made of all hospitals in the system. As a result of this tremendous space shortage, Mr. Cooney informed me that an architectural firm has been employed in order to make a complete report on deficiencies of space and how they may be corrected as well as the possibility of constructing a new replacement hospital.

The only new program added since my last survey is the Geriatric Research and Education Center.

2. BUILDING MANAGEMENT

This service is authorized 133 full-time employees and 17 part-time employees. Currently, they are 4 full-time employees short and 3 part-time employees short. Recruiting is now ongoing to fill the vacancies which exist. Recently, management authorized this service to remove all unnecessary signs, including the tons of paper signs affixed to walls and doors by scotch tape throughout this hospital. It is very difficult to keep these signs off doors and walls. I was with the Chief of Building Management on Tuesday morning and I witnessed him remove at least a dozen paper signs from a wall and that afternoon I was in the same area and all of the signs he had removed earlier were back on the wall. I was advised that this is a daily occurrence and consequently, management is going to have to instruct all chiefs of services to keep these paper signs off the walls and doors because when they are removed it also removes paint and finish from the doors. Building Management is to be complimented on the way that they keep this hospital so clean. I feel that the new Chief of Building Management has certainly brought some new innovations in the way a housekeeping person is to perform his duties in an expert manner. Recently the laundry was partially remodeled with new pass through washer extractor machines.

3. MEDICAL ADMINISTRATION

This service is now conducting surveys on a percentage of patients admitted within a certain length of time. The last time study reflected that 50% of all applicants have been admitted within one hour. We were informed that there was selectivity in admitting patients; however, in reviewing all of the reports, it appears that only 2% of the applicants applying for hospitalization are rejected. The turnover rate is quite high, and in fact, the average length of stay is only 12.06 days. Part of the Outpatient Clinic is still located over on the old Ft. Snelling reservation in an old military barracks and this property has been deeded to the state of Minnesota for their Historical Society. If the state suddenly decides that they need this particular area for the Historical Society, the Veterans Administration would have to vacate those premises immediately. As a consequence VA Central Office should start making some very definite plans in relocating the remaining functions of the Outpatient Clinic over into the hospital complex itself.

4. RECORDS

All of the charts are current or within time standards. There are only three or four charts about 4 weeks old. This is due to the doctors being transferred. The 21 day summaries are current. None of the compensation and pension examinations have been returned as inadequate for rating purposes.

5. NURSING HOME CARE

This hospital does not have a nursing home care unit; however, plans are being made to build a 120 nursing home bed complex. There are 122 beds under contract and the budget is adequate. Forty-six of the 122 nursing home care beds are occupied by service connected veterans. The average cost is now $30 per day.

6. ENGINEERING SERVICE

Fire and Safety: Currently, a contract is ongoing to upgrade the fire alarm system for $300,000. It is undecided whether or not there will be exterior stairwells constructed on the buildings or whether they will permit the station to sprinkle the entire patient treatment areas. Engineering Service feels that sprinkling the entire patient treatment areas would be more practical than investing in stairwells. At least if a fire breaks out in one area, and if being sprinkled, the fire would be contained and smothered at that point rather than to try and evacuate the building by stairwells. It is proposed that the boiler plant will be replaced in 1980. Currently, they are in the design phase for remodeling some of the Radiology Section. Pharmarcy expansion is practically 90 percent complete and the pharmacy will be moving into the new quarters probably by May 1. Central air conditioning is vitally needed.

7. NURSING SERVICE

Since the present Chief of Nursing arrived four years ago, there has been a continual staff improvement. There is need for additional staff in the areas of support services. Currently, the FTE is 554. The turnover rate in nursing is about 20 percent. This service is affiliated with 7 different nursing schools. Effective June 1, 1978, a new state law becomes effective wherein it is required that a registered nurse must have at least 15 units of education every two years in order for her to become licensed or remain licensed in the state of Minnesota.

8. RECOMMENDATIONS

1. A new replacement hospital should be constructed to replace the old 1926 and 1927 vintage buildings.

2. In the event a new replacement hospital cannot be constructed, then centralized air conditioning should be considered as a priority project.

3. Clip boards at foot of beds with patient records should be contained in the charts at the Nurses Station.

4. The intake and output charts should be removed from the outside of the room doors and placed in the nursing charts.

5. Duplication of patients names are not needed, particularly in the 16 bed wards.

6. New types of patients lists should be utilized rather than the large unsightly peg boards which are now on display at the nurses stations.

7. Central Office should authorize either sprinkler or stairwells to comply with JCAH and OSHA safety standards.

8. Paper signs should be removed and kept off walls and doors. If necessary, an educational program should be instituted to accomplish this purpose.

9. All of the Dreft boxes of soap and cleansing powders should be stored in the storage rooms instead of on sinks and on the paper towel dispensing boxes.

9. EXIT INTERVIEW

Upon leaving this station I had an exit interview with Mr. Walton H. Bonner, Assistant Director, since Mr. Cooney had left on Tuesday for Washington, D.C. All of the above mentioned recommendations were outlined to Mr. Bonner and he made numerous notes. I thanked Mr. Bonner for his splendid cooperation and asked him to express my appreciation and thanks to Mr. Cooney and to the staff whom I interviewed while making the survey.

R. O. WIKOFF
Field Representative

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

[illegible] 1978

IN REPLY
REFER TO: 10C1

Mr. Robert L. Ashworth
Director, National Veterans Service
Veterans of Foreign Wars of the
  United States
200 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Ashworth:

Thank you for your letter of May 19. I am pleased to respond to the recommendations in the survey report on the Minneapolis VA Hospital.

I recognize the future need to modernize or replace many of our older hospitals; including the Minneapolis facility. There are no plans for such a major construction project at this time, however, projects to eliminate facility deficiencies are being planned and programmed to the extent resources and priorities permit.

Centralized air conditioning for this hospital will be considered in conjunction with systemwide demands.

The Hospital Director has been contacted concerning the clip boards containing patient records at the foot of the beds. He has agreed to review this practice and remove any records that might compromise the privacy of the patients, placing all appropriate charts in the medical record.

The Hospital Director is taking steps to eliminate the duplication of the patients' names in the wards.

New and more decorative types of patient lists are being sought to replace the present peg boards.

A Minor Miscellaneous Project, "Additional Automatic Fire Sprinklers", is being considered for a future fiscal year.

"To care for him who shall have borne the battle, and for his widow, and his orphan." – ABRAHAM LINCOLN

A new sign system is being installed at the present time. Also, new sign holders have been ordered for offices throughout the hospital.

Soap and cleansing powders are now in storage areas.

Please express my appreciation to Mr. Wikoff for this report.

Sincerely yours,

JOHN D. CHASE, M.D.
Chief Medical Director

Mr. SCHWAB. I would say we also made a survey in December of last year which isn't yet ready for submittal, but when it is it will be forwarded to this committee.

Mr. STEINBERG. We will be glad to have that. Do you have an estimate as to when the December report will be completed?

Mr. SCHWAB. Shortly. Within the next 2 or 3 weeks.

Mr. STEINBERG. May I ask the Legion if you have recent visitation reports that you would like to submit?

Mr. RIGGIN. I am not aware, but if we do, I am sure we have something in the last 18 months at least. We will be more than happy to supply it.

Mr. STEINBERG. Please proceed.

Mr. SCHWAB. Let me say at the outset that the VFW fully supports the replacement of the Minneapolis facility. We support a strong VA hospital and medical care system, specifically for veterans. We want to see this maintained.

We have sympathy for communities that have overbuilt hospitals and overbedded. However, we do not intend to sit by and watch these community hospitals, built for financial gain, try to tear down the VA hospital and medical care system merely to fill their empty hospital beds.

I talked to the gentlemen who are here from Minnesota and who are here from our organization, and they think that the commissioner of the State of Minnesota, Department of Veterans' Affairs, would be the best spokesman at this point, and I call on Donald Miller to make whatever comments he so desires at this time.

Mr. MILLER. Thank you. I did not come with any prepared remarks. However, I am concerned as to what will happen to our 550,000 veterans who are in the State of Minnesota.

Part of the testimony that you are receiving this afternoon, you are hearing about the population being served; and the geographical boundarys. You can draw county lines and come up with 72 counties.

I submit to you that there are more counties than this, because the entire 87 counties of Minnesota are being served by the Minneapolis VA Center.

The way this is being done is not only from transfers, but also we have an assembling point through our State veterans' homes. Presently we operate two State veterans' homes. One is located in Hampton County, one is in Dakota County and both of these are in the seven-county metro area, yet they are receiving members from throughout the entire State.

Therefore, when we are talking about the care of persons and we are indeed pleased over the many years that I have been involved in veterans work as a volunteer, and as a so-called professional, that we have been able to have such wonderful service with the VA Medical Center in Minneapolis.

We are serving the entire 87 counties in the VA Medical Center in Minneapolis through these members in our home. Some of them are for short periods of time, some of them for extended periods of time.

Our ages at the Minnesota Veterans' Home presently range from 17 to 98, so we are covering the entire spectrum.

We in Minnesota have a total of 740 beds and members in our homes of which all but 18 are veterans. The others—our homes are available to wives, widows and mothers of Minnesota veterans.

Our population in these homes are currently ranging from 690 to 740 persons, and the veterans are eligible for the service at the Minneapolis hospital.

I believe it is indicative of the attitude of our Minnesota veterans in that we in Minnesota are in the process within the next couple of weeks of completing our agent orange survey. I don't believe there is another State in the Nation that has attempted this.

We have 10,000 veterans, Vietnam combat veterans who have indicated they wished examinations at the VA Medical Center in Minneapolis.

We are having excellent communications and service with the people from the Minneapolis VA Hospital, and VA Medical Center.

Finally, I submit—possibly it will not be available in time to assist you with your study. However, it would be something for your files—that we in Minnesota have undertaken a department survey of the Minnesota veterans, their age, the demographics, geographics, financial, economic disability, physical condition, and so on.

We have a target date on that of June 30. I regret to say that we will probably be backing that up about 45 days, but when it is available I will see that the copies are furnished to your office.

Mr. STEINBERG. I wonder if you would also like to say a word or two about what we understand to be a plan to expand, rather substantially, the capacity of the State homes?

Mr. MILLER. The formula provided by the Veterans' Administration, as far as in support of nursing care beds in Minnesota, would provide that we should have something in excess of 1,300 nursing care beds in our State.

These particular goals have been met already by the State of Rhode Island, Nebraska, and other States are well on the way.

We in Minnesota presently have 85 beds in place. We have just received permission to expand that to 181 beds with existing equipment and buildings that we have.

However, we have not had the staff available because of legislative and budget restraints. We are progressing into these 181 beds due to the fact that we are completing a 250-bed nursing care units that should be completed this fall on the Minneapolis campus. We do have the staff authorized for the new unit.

When we move into the new 250-bed unit, at that point in time we will then be abandoning the 181 beds, because we don't have the staff; even though they are licensed and equipped. We do not have the staff.

Mr. STEINBERG. That will be a pickup of some 70 beds at that point?

Mr. MILLER. It will be about 70 beds. However, we are talking again about local situations. We presently have 62 veterans in our veterans' home who are actually receiving nursing care as such.

But, because we do not meet the minimum staffing requirements, we cannot register them, and they are being carried as domiciliary members rather than nursing care.

Mr. STEINBERG. So, you contemplate transferring those patients to the new facility when that is ready?

Mr. MILLER. That is correct. At last count we had 231 people on the waiting list, and we have not taken a serious application in 5 months.

Mr. STEINBERG. I am afraid I don't understand the relationship between the 100-bed expansion that you spoke of at the outset, and the opening of the new 250-bed unit.

Would that, down the road, be 100 beds in addition to that?

Mr. MILLER. We have 85 beds in place occupied. We have just received permission to expand this to 181. Again, it is because of existing buildings that we have, but we do not have the staff for the other 96 beds that have just been licensed.

By borrowing the staff that we are authorized for the new 250-bed unit, we can start bringing that staff aboard early to start caring for these patients, and start in-service training of our staff.

When that day comes that we can move into the new 250-bed unit, we will conceivably have 181 patients and the staff that would complement that to move into the 250. At that point we will be vacating 181 beds.

Mr. STEINBERG. Over this period of time you will go from 80 to 250 beds?

Mr. MILLER. That's correct.

Mr. STEINBERG. Do you have present plans to expand the nursing care beyond that?

Mr. MILLER. We have plans on paper, a long-range plan over the next 9 years to conceivably expand to approximately 900 nursing care beds in the metropolitan area; and probably another 400 nursing care beds.

Again, this is on paper. It is a concept.

Mr. STEINBERG. What is the projected date for opening the 250-bed unit?

Mr. MILLER. That will be done the first of August. Two weeks ago I finally received a list of the equipment which we have out for bids. I am supposed to have the bids open for next week. I am sure my money is coming in short, and also delivery date.

I anticipate that I will have the people in the home finally sometime in October.

Mr. STEINBERG. Does that include the recruitment of the additional staff necessary for what you are beginning to do now?

Mr. MILLER. That's right. It has started. I believe we brought 7 nurses aboard this far out of 60 that are authorized.

Mr. STEINBERG. Does Mr. Pavek have anything to add?

Mr. SCHWAB. Thank you for asking. Our Quartermaster John O'Neill would like to respond to that.

Mr. O'NEILL. My name is John O'Neill. I am the State adjutant from the Department of Minnesota, Veterans of Foreign Wars.

In Minnesota we have an excellent veteran service officer system which makes it a habit of daily taking veteran patients to the VA hospital system. Along with that I made a survey of the counties within 75 miles of the VA hospital. We find that there are 378,900 veterans that live within this 75-mile radius up in Minneapolis. There are 140,000 or more World War II veterans, and 7,500 are World War I veterans.

The other thing that I would like to add is in Minnesota we had a Vietnam bonus in that there were 187,000 Minnesota men that served in the Vietnam war. We had the highest ratio of people serving in Vietnam of any other State in the Nation.

For example, nearly 75 percent of the Marines from Minnesota served in Vietnam. This again, because the helicopters provided more people coming back with disabilities because the helicopter was able to assist in saving more lives.

I have some copies I would like to pass out. Thank you.

Mr. STEINBERG. Thank you.

Rick, would you like to proceed for the Disabled American Veterans?

TESTIMONY OF JOHN HEILMAN, LEGISLATIVE DIRECTOR FOR THE DISABLED AMERICAN VETERANS

Mr. HEILMAN. My name is Rick Heilman. I am the legislative director for the Disabled American Veterans. The DAV does support construction of the Minneapolis hospital. Dr. Baganz has gone into some detail here this afternoon and presented, I believe, a valid case for the building of that hospital.

The existing structure is some 50 years old, and I believe if you look at the Minneapolis hospital in connection with the rest of the VA system, you will find that it is slightly under in terms of hospital and operating beds and does demonstrate a need in the area of nursing home care beds.

The facility being built would not add new beds to the system. We have also heard from the gentleman representing the HSA's in the communities, and a gentleman from the medical school.

Without preempting the decision, the review that will be conducted by your organization, I believe that it might be safe to say that it's not outside the realm of possibility that your organization will not come up with a negative report in terms of construction of that facility; although, I am sure you may have some very valid and useful comments regarding the scope of the operation concerned.

This relates to another issue that is pertinent to today's discussion, not only construction of the specific hospital, but the relationship between HSA's and the private medical community to expansion and improvements that are made in the VA health-care system.

Certainly it is necessary and important to have an ongoing dialog and to profit from the views and comments of the private medical community in terms of contemplated changes that are being considered in the VA health-care system.

Keeping that in mind, the DAV does take the position that in terms of the destiny of VA health care, the future expansion of the system, and how the health care needs of our veteran population would be met through that system, we believe the ultimate and final control of the VA system should remain in the hands of the VA and the Congress of the United States and no other.

I just wanted to add that additional point. That is all I have to say at this time.

Mr. STEINBERG. Thank you, Rick.

Mr. Brinsky from AMVETS.

TESTIMONY OF GABRIEL BRINSKY, NATIONAL SERVICE AND LEGISLATIVE DIRECTOR, AMVETS

Mr. **Brinsky.** Mr. Steinberg, I have only a few observations to make on behalf of AMVETS.

First and foremost, we are interested, above all, in the continuation of the health care as provided by the Veterans' Administration for our veterans.

As for the construction of the hospital in question, knowing the methodology and the extensive studies conducted by the Veterans' Administration, we have had no occasion in the past to materially disagree with any decisions which the Department of Medicine and Surgery and the Administrator have made in regard to the construction, maintenance, or site location of hospitals.

We would like to go on record to express our agreement with the proposed construction. Thank you.

Mr. **Steinberg.** Thank you very much.

Now, finally we have a group of organizations from Minnesota concerned with the broad issues affecting health planning and provision of health services within the State, and within the Minneapolis area. I wonder if they have something to say briefly at this point.

Ms. Kiehne, do you want to start off for the Council of Community Hospitals?

TESTIMONY OF A PANEL CONCERNED WITH HEALTH PLANNING AND PROVISIONS OF HEALTH SERVICES WITHIN THE STATE OF MINNESOTA AND MINNEAPOLIS AREA CONSISTING OF LYNN KIEHNE, ASSOCIATE DIRECTOR OF THE COUNCIL OF COMMUNITY HOSPITALS; DR. A. STUART HANSON, MINNESOTA MEDICAL ASSOCIATION

Ms. **Kiehne.** I have just a brief statement, and I do have it written.

My name is Lynn Kiehne. I am associate director of the Council of Community Hospitals.

The Council of Community Hospitals, an organization serving the 35 public and private community hospitals located within the seven-county metropolitan area of Minneapolis and St. Paul, Minn., wishes to make a few comments about the proposed 845-bed, $220 million Veterans' Administration Hospital to be located in Minneapolis, Minn.

Through the past several years, our hospitals have exerted enormous energies in their struggle to reduce health-care costs. We've developed a competitive strategy to contain these costs and feel that we have made significant progress.

The tentative decision to construct a new veterans hospital of the size that's purported within our community may be inconsistent with this strategy.

The true test of actual need is: If veterans were provided a choice of care at various institutions, including the VA hospital, what size facility would be appropriate?

Our hospitals are genuinely concerned about replacing a facility costing $220 million, which totally dwarfs our cost-cutting efforts to date, without thorough analysis of whether it is needed and how it fits into our community.

Furthermore, the credibility of the Government's total health-care planning process appears to be seriously jeopardized. From our perspective, it seems that this process may effectively apply only to the non-Federal, private, and public sectors.

We appreciate the role and the tradition of the Veterans' Administration in providing health-care services to our veterans. We do question, though, whether our veterans could be better served if they were given the choice to obtain health care at any facility of their choice. By providing veterans medical benefits through a voucher system, we will make prospects for quality health care for veterans even better, through providing them several options.

In turn, the proper size of the new VA hospital can be determined through a process of veteran choice. The veterans who prefer the VA can use their services, while others can have their needs served at the facilities of preference.

Lastly, until a competitive environment is firmly in place so that certificate-of-need can be significantly modified or abolished, we believe that the veterans hospital should submit itself to the same scrutiny as our other public and private hospitals.

I guess in adding to that, one thing that we would like to see would be a suspension of a decision as to whether to replace the veterans hospital in this proposed size until its impact on the community can be tested in relationship to other hospitals already serving the community.

Mr. **Steinberg.** Do you have a timetable in terms of when you think the results of such a testing would be available?

Ms. **Kiehne.** I think that would be something that would be done in conjunction with the A-95 review that the health board is now conducting.

Mr. **Steinberg.** Would that require that the university facility's certificate-of-need process also run its course in order for that new construction to be taken fully into account?

Ms. **Kiehne.** I would assume that since that hospital also serves the same community that it would also be figured in.

Mr. **Steinberg.** Which would presumably mean that we are talking about a time delay until the end of the year if I understand what has been outlined to us about the HSA process there.

Ms. **Kiehne.** Possibly.

Mr. **Steinberg.** Mr. Lohmer or Dr. Hanson, whichever of you would like to speak on behalf of the Minnesota Medical Association.

Dr. **Hanson.** I represent the Minnesota Medical Association. The Minnesota Medical Association has a long and active history for participation in both cost containment and planning activities.

Our sponsorship of a cost-containment commission, composed of community, business, labor, and medical leaders in Minnesota, and regional physician health planning groups which provide medical expertise and planning recommendations to local health systems agencies, all speak of our commitment to cost-effective quality health care.

Significant and real community participation has moved health planning in Minnesota from a paper exercise to a real force for change. Persons and groups which have differing perspectives have openly discussed health planning issues and implemented negotiated decisions.

In most cases, open and effective lines of communication exist. Moreover, health planning is not an isolated instance of community participation in health. The peer review system which is mandated for titles V, XVIII, and XIX patients, also covers virtually all private acute-care hospital admissions in our region.

The one notable exception to this process has been Federal hospitals; most notably, the Veterans' Administration hospitals. We feel that the VA hospital system should join the "mainstream" of health-care planning and delivery.

We feel this would be a cost-effective decision for all taxpayers, and would result in a higher quality, more available care for all eligible veterans.

Our perspective does not fail to realize that the VA hospital in Minneapolis and the VA hospital system play a unique role in the delivery of health-care services.

The contributions of the VA system in teaching, research, and patient care should be applauded, encouraged, and publicly recognized. Locally, the coordination of teaching and research programs, especially between the university and the VA, have benefited both the public and veterans.

Though we are skeptical of the cost effectiveness of the mandated certificate-of-need process, we support community involvement in health planning decisions.

To that end, we have urged the metropolitan health board, or health systems agency, to pursue an agreement with the VA hospital to establish the ground rules for a certificate-of-need process similar to that required of other hospitals.

As part of this agreement, some form of commitment by the VA and the health board to the process and its results should be developed. In this form, the following issues could be discussed: (1) The relationship of the VA's proposal to area's health plans and the VA's own long-range plan, if any; (2) the documented need for services and beds; (3) special needs of the target population and alternative ways in meeting those needs; (4) needs of research and teaching; and (5) the relationship of services proposed to be offered and their availability and cost in other institutions or programs.

There should be a significant effort made by university hospitals and the VA hospital to discuss and then implement decisions in areas of potential duplication.

Because of the timing of the proposed replacements of the VA and university facilities, we are presented in an unprecedented opportunity for "designing in" cost-effective health-care delivery between two of the largest providers of care, research, and teaching in our region.

Every effort should be made to parallel the renovation and expansion plans of these two hospitals.

Finally, there is the question of peer review. All patients, regardless of who pays the bills, or where they are treated, should be assured of quality medical care.

The federally mandated PSRO program which provides community peer review to almost all hospitalized patients—titles V, XVIII, and XIX and private—in our region can and should provide this function in Federal hospitals. Strong consideration should be given to extending the PSRO program to the VA hospital as an acceptable alternative to the VA's present review system.

A consistent uniform system can support understanding between the private and Federal sectors and concurrently assure cost-effective quality care to each patient.

I thank you for this opportunity to make this presentation, and I have some personal thoughts, but I will save those until open discussion.

Mr. STEINBERG. We will now take a 5-minute break until 2:31, and then we will proceed with some questions and roundtable discussions.

[Whereupon, a short recess was taken.]

Mr. STEINBERG. Let's get started.

Mr. Cralle of the Veterans' Administration has requested an opportunity to respond very briefly at the outset to some of the concerns that have been raised by the other participants.

If there is no objection to that, because I think it will provide some focus, I would like to proceed to recognize him for no longer than 2 minutes, and Dr. Baganz for no longer than 2 minutes.

Then we will get into questions that we may have and that others of you may have to ask of each other.

Mr. CRALLE. Thank you, Jonathan.

I would just like to say that while the VA desires to be a helpful member in any community which operates, we have a responsibility also to be a helpful member to the community of the Nation at large. We must operate within the existing laws and regulations.

I would like to bring to the attention of all concerned that we believe that we have demonstrated the need, and that the need exists for a project of this size.

So, should this project slip from this budget to the 1982 budget, there would probably be a cost of in excess of $15 million, perhaps $15.5 million to do the same size project. That would be a cost to all the taxpayers in the Nation at large.

We feel like we have a responsibility to operate under the current and existing laws.

I would like to ask Dr. Baganz to expand on a few other points.

Dr. BAGANZ. Mr. Steinberg, I would like to express appreciation to all of those here, that I think this kind of meeting is very helpful for sharing information and for mutual understanding.

I think many of the problems in the planning process that have occurred have been the adversary roles that have been built on suspicion, mistrust, lack of understanding, and I would certainly encourage exchange of information. I am pleased that we have had this opportunity. It doesn't necessarily mean the rest will be a totally unanimous consensus of our opinions, but I think this is useful and educational.

Along the same line, I would like to say that the VA has been very supportive of the planning process. It has been an active participant. I have attended every meeting except two of the National Council on Health Planning and Resource Development, not only here in Washington, but those that have been held in Los Angeles and Denver.

The VA participates in the three of the five tiers involving that planning process. Mr. Cooney is an appointed representative for the Chief Medical Director to the local HSA. We also have local representatives appointed centrally to the SHCC's.

We do not participate at the other two tier levels which are political or elected positions, but we do support the process and support what Mr. Cralle says. We are operating under the laws of Congress. The Congress in its wisdom, and we agree with it, has reserved to itself the final decision on such things. That is what Public Law 96–22 reestablished; that Congress wanted to reserve to itself final judgment of need. We would hope for a favorable final judgment from the two committees of Congress.

As to the involvement of the planning process——

Mr. STEINBERG. You are now into Maury's last minute.

Dr. BAGANZ. I would just like to mention as to our ability to participate early on, we have a certain protocol in Federal Government, that we were under an embargo of release of certain information this being in the President's budget which was until January 28, 1980.

As you notice, on January 29, 1980, we mailed the A–95 letter-of-notification. It is because we could not upstage the President in releasing that information in his budget, that this time frame was followed.

Therefore, we did go to you earlier and the 60-day time for you to respond to us starts when you received that letter.

In response to Mr. Miller, I wanted to agree with you, that we do serve a much larger area. The 72 counties means that at least half of the patients using the VA system come from those counties. There are 215 other counties that this hospital serves. Twelve percent of the workload comes from those other 215 counties. Eighty-eight percent of the workload comes from 72 counties in the primary service area.

As to the bed sizing, we do use community lengths of stay. Mr. Peck is here and perhaps he can comment upon that. We use the data of PAS length of stay for bed sizing, for acute medicine, and surgery services.

In other words, we have used this bed sizing model that has been concurred by the General Accounting Office and the VA using community lengths of stay.

Mr. STEINBERG. Thank you.

Let me, if I may, follow up on a few items that you and Maury just raised.

I believe it is correct that the A–95 process and the A–95 circular refer to notification at the earliest feasible time. Is that correct?

Dr. BAGANZ. That's correct.

Mr. STEINBERG. It seems to me that if the Administration's position is—and I would like to address this to Mr. Coy—that the only feasible time is upon a release of a Presidential decision, either in the President's budget or at some other time, that it would be helpful if the

A–95 process were made explicit in that regard so that expectations to the contrary would not be created.

Has that ever been explored to your knowledge?

Mr. COY. I am not sure that has been explored from the viewpoint of changing the A–95 process. The A–95 process is, at times, in conflict with an executive branch decision, that is embargoed until that decision is announced.

I think the system has not worked all that bad in the past in most instances. My guess is that there has been no consideration to amend the process.

Mr. STEINBERG. But, the executive branch practice with respect to A–95 has been as Dr. Baganz has outlined?

Mr. COY. Yes. We wait until after the budget is released.

Mr. STEINBERG. Has there been any exception to that as far as you are aware? I mean, have there been any VA construction projects—and if you are not aware of any now, perhaps you could provide more information for the record—where a notification was made to the community prior to the official release of the President's budget or another document officially approved by the President?

Mr. COY. Let me provide that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

In accordance with OMB Circular dated January 2, 1976, the Veterans' Administration notifies State and Areawide Clearinghouses of applicable direct Federal development projects. These notifications are made in advance of the budget submission in sufficient time to ensure that the clearinghouse comments are available for consideration with the budget. Approximately 50–60 construction projects per year require notification to the Clearinghouses; attached is a representative sample of notification letters submitted to Clearinghouses during 1976, 1977, 1978, and 1979. The Veterans' Administration has not been authorized to make notification to Clearinghouses for replacement hospitals until approved by the Administration and until notification of appropriate congressional committees and State congressional delegations.

MAY 27, 1976.

OFFICE OF PLANNING AND BUDGET,
Atlanta, Ga.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is being planned at the Veterans Administration Hospital, Atlanta, Georgia. The estimated cost of the project is $5,201,000.

The project proposes to construct a two-story structure adjacent to the Atlanta VA Hospital. This new building, which will be connected to the hospital by a corridor, will house 120 nursing home care beds and related support facilities. This nursing home care unit will enable the VA hospital to better provide for the extended care needs of the veteran patients served by this facility.

This notification should be coordinated with the appropriate health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

MAY 27, 1976.

ATLANTA REGIONAL COMMISSION,
Atlanta, Ga.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is being planned at the Veterans Administration Hospital, Atlanta, Georgia. The estimated cost of the project is $5,201,000.

The project proposes to construct a two-story structure adjacent to the Atlanta VA Hospital. This new building, which will be connected to the hospital by a corridor, will house 120 nursing home care beds and related support facilities. This nursing home care unit will enable the VA hospital to better provide for the extended care needs of the veteran patients served by this facility.

This notification should be coordinated with the appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Statewide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

JUNE 1, 1976.

STATE CLEARINGHOUSE,
Bureau of the Budget, State House, Springfield, Ill.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a project to correct electrical deficiencies that is being planned at the Veterans Administration Hospital, Chicago (Lakeside), Illinois. The estimated cost of this construction project is $1,245,000.

This project proposes to replace the main switchgear, disconnects, and feeders at this VA hospital. The action is required to insure growth capacity and to provide adequate fault current protection.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

JUNE 1, 1976.

NORTHEASTERN ILLINOIS PLANNING COMMISSION,
South Riverside Plaza, Chicago, Ill.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a project to correct electrical deficiencies that is being planned at the Veterans Administration Hospital, Chicago (Lakeside), Illinois. The estimated cost of this construction project is $1,245,000.

This project proposes to replace the main switchgear, disconnects, and feeders at this VA hospital. The action is required to insure growth capacity and to provide adequate fault current protection.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95. Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.
Chief Medical Director.

MAY 20, 1976.

OFFICE OF INTERGOVERNMENTAL RELATIONS,
Raleigh, N.C.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a project to correct electrical deficiencies that is being planned at the Veterans Administration Hospital, Durham, North Carolina. The estimated cost of the project is $1,825,000.

The project proposes to provide a new electrical distribution system that meets current national codes and to also provide required emergency power for the hospital.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.
Chief Medical Director.

MAY 20, 1976.

TRIANGLE J. COUNCIL OF GOVERNMENTS,
Research Triangle Park, N.C.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a project to correct electrical deficiencies that is being planned at the Veterans Administration Hospital, Durham, North Carolina. The estimated cost of the project is $1,825,000.

The project proposes to provide a new electrical distribution system that meets current national codes and to also provide required emergency power for the hospital.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Statewide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

MAY 4, 1977.

OFFICE OF PLANNING AND BUDGET,
Atlanta, Ga.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, Part II, this is to advise you of a construction project to add an ambulatory care facility at the Veterans Administration Hospital, Chamblee (Atlanta), Georgia. The estimated cost of this project is $8,361,000.

This project proposes to construct a new ambulatory care addition to the hospital of approximately 69,000 gross square feet which will include a basement and ground floor with capacity for future vertical expansion. Approximately 33,000 gross square feet of existing space within the hospital will require internal adjustments and renovation to provide the overall space for the outpatient program.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

MAY 4, 1977.

ATLANTA REGIONAL COMMISSION,
Atlanta, Ga.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, Part II, this is to advise you of a construction project to add an ambulatory care facility at the Veterans Administration Hospital, Chamblee (Atlanta), Georgia. The estimated cost of this project is $8,361,000.

This project proposes to construct a new ambulatory care addition to the hospital of approximately 69,000 gross square feet which will include a basement and ground floor with capacity for future vertical expansion. Approximately 33,000 gross square feet of existing space within the hospital will require internal adjustments and renovation to provide the overall space for the outpatient program.

This notification should be coordinated with appropriate health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

John D. Chase, M.D.,
Chief Medical Director.

May 5, 1977.

State Clearinghouse,
New York State Division of the Budget,
State Capitol, Albany, N.Y.

Gentlemen: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, Part II, this is to advise you of a new structure that is being planned at the Veterans Administration Hospital in Canandaigua, New York. The estimated cost of this project is $1,347,000.

The project proposes a new building to locate all engineering shops and offices into a single structure. This will permit Engineering Service to vacate their existing building which will then be reverted to the Sonnenburg Estate.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

John D. Chase, M.D.,
Chief Medical Director.

Genesee Finger Lakes Regional Planning Board,
Ebenezer Watts Building,
Rochester, N.Y.

Gentlemen: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, Part II, this is to advise you of a new structure that is being planned at the Veterans Administration Hospital in Canandaigua, New York. The estimated cost of this project is $1,347,000.

The project proposes a new building to locate all engineering shops and offices into a single structure. This will permit Engineering Service to vacate their existing building which will then be reverted to the Sonnenburg Estate.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

John D. Chase, M.D.,
Chief Medical Director.

July 28, 1977.

Office of the Governor,
State Clearinghouse, State Office Tower,
Columbus, Ohio

Gentlemen: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is planned at the Veterans Administration hospital in Cincinnati, Ohio. The estimated cost of the project is $3,514,000.

The project proposes to expand laboratory, radiology, cardiac catheterization and dental services, all significantly below criteria, with approximately 16,600 gross square feet of new construction for the second floor of Building No. 1 above the new outpatient addition.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

John D. Chase, M.D.,
Chief Medical Director.

JULY 28, 1977.

OHIO-KENTUCKY-INDIANA (OKI),
Council of Governments,
Cincinnati, Ohio

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is planned at the Veterans Administration hospital in Cincinnati, Ohio. The estimated cost of the project is $3,514,000.

The project proposes to expand laboratory, radiology, cardiac catheterization and dental services, all significantly below criteria, with approximately 16,800 gross square feet of new construction for the second floor of Building No. 1 above the new outpatient addition.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

APRIL 5, 1978.

OFFICE OF INTERGOVERNMENTAL RELATIONS,
Office of the Governor, Capitol Station,
Baton Rouge, La.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is being planned at the Veterans' Administration Hospital, Alexandria, Louisana. The estimated cost of the project is $11,000,000.

This project proposes to relocate Surgical Service and major clinical support functions, *e.g.*, laboratory and radiology, from Building No. 2 to Building No. 7 (presently a general medical bed building). Intermediate medicine will be relocated from Building No. 7 to Building No. 2. Also involved is the determination of the relocation of admitting, Medical Administration Service, and out patient clinic services from Building Nos. 2 and 3 to Building No. 7. Outpatient clinic services will be consolidated in Building No. 7 with the functions displaced relocated to Building Nos. 2, 3, or other available space.

This notification should be coordinated with appropriate health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

APRIL 5, 1978.

CENTRAL REGIONAL CLEARINGHOUSE,
% *Kisatchie-Delta Economic Development District Council,*
Alexandria, La.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is being planned at the Veterans' Administration Hospital, Alexandria, Louisiana. The estimated cost of the project is $11,000,000.

This project proposes to relocate Surgical Service and major clinical support functions, e.g., laboratory and radiology, from Building No. 2 to Building No. 7 (presently a general medical bed building). Intermediate medicine will be relocated from Building No. 7 to Building No. 2. Also involved is the determination of the relocation of admitting, Medical Administration Service, and outpatient clinic services from Building Nos. 2 and 3 to Building No. 7. Outpatient clinic services will be consolidated in Building No. 7 with the functions displaced relocated to Building Nos. 2, 3, or other available space.

This notification should be coordinated with appropriate health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

APRIL 5, 1978.

GOVERNOR'S BUDGET AND PLANNING OFFICE,
Executive Office Building,
Austin, Tex.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a construction project that is being planned at the Veterans Administration Hospital, Amarillo, Texas. The estimated cost of the project is $5,500,000.

This project proposes to provide central air conditioning for all patient and support areas in Building Nos. 1, 4 and 7 and the partitioning of large ward areas for patient privacy. Also included in the project is the replacement of the visual nurse call system and updating of the air, oxygen, and vacuum system.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

APRIL 5, 1978.

PANHANDLE REGIONAL PLANNING COMMISSION,
Amarillo, Tex.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a construction project that is being planned at the Veterans Administration Hospital, Amarillo, Texas. The estimated cost of the project is $5,500,000.

This project proposes to provide central air conditioning for all patient and support areas in Building Nos. 1, 4 and 7 and the partitioning of large ward areas for patient privacy. Also included in the project is the replacement of the visual nurse call system and updating of the air, oxygen, and vacuum system.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

JULY 17, 1978.

BUREAU OF INTERNATIONAL RELATIONS,
Division of State Planning, Department of Administration,
Tallahassee, Fla.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, Part II, this is to advise you of a project to establish a Veterans Administration outpatient clinic in Broward County, Florida. The estimated cost of activating this clinic is $2,000,000.

The project proposes to lease a structure of approximately 48,000 gross square feet which will be used for providing ambulatory care to eligible veterans. When completely activated, we project that the clinic will provide 65,000 outpatient visits annually. In the past few years, the demand for ambulatory care in Broward County has increased dramatically with the large veteran migration to Florida. This new clinic will provide adequate space and the appropriate environment for this vital service.

Thus, notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the state clearinghouse.

Thank you for your attention in this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

JULY 17, 1978.

SOUTH FLORIDA REGIONAL PLANNING COUNCIL,
Miami, Fla.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, Part II, this is to advise you of a project to establish a Veterans Administration outpatient clinic in Broward County, Florida. The estimated cost of activating this clinic is $2,000,000.

The project proposes to lease a structure of approximately 48,000 gross square feet which will be used for providing ambulatory care to eligible veterans. When completely activated, we project that the clinic will provide 65,000 outpatient visits annually. In the past few years, the demand for ambulatory care in Broward County has increased dramatically with the large veteran migration to Florida. This new clinic will provide adequate space and appropriate environment for this vital service.

Thus, notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the areawide clearinghouse.

Thank you for your attention in this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

JANUARY 22, 1979.

STATE CLEARINGHOUSE,
Office of Economic and Community Development,
Charleston, W. Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a construction project that is under consideration at the Veterans Administration Medical Center, Beckley, West Virginia. The estimated cost of this project is $7.5 million.

This project proposes to add a 2 or 3 story addition to the main hospital building to provide for the updating of services such as Ambulatory Care, Laboratory, Pharmacy, Radiology, Supply, Education and Warehouse. Additionally, some internal alterations will be required in the areas being relocated or expanded in place.

We welcome any comments developed during your coordination of this project notification and especially those of the health planning agencies which function in southwestern West Virginia served by this VA medical center. This includes Health Systems Agencies and the State Health Coordinating Council in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JAMES C. CRUTCHER, M.D.,
Chief Medical Director.

JANUARY 22, 1979.

REGION I PLANNING AND DEVELOPMENT COUNCIL,
Bremerton, W. Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of a construction project that is under consideration at the Veterans Administration Medical Center, Beckley, West Virginia. The estimated cost of this project is $7.5 million.

This project proposes to add a 2 or 3 story addition to the main hospital building to provide for the updating of services such as Ambulatory Care, Laboratory, Pharmacy, Radiology, Supply, Education and Warehouse. Additionally, some internal alterations will be required in the areas being relocated or expanded in place.

We welcome any comments developed during your coordination of this project notification and especially those of the health planning agencies which function in southwestern West Virginia served by this VA medical center. This includes Health Systems Agencies and the State Health Coordinating Council in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Statewide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JAMES C. CRUTCHER, M.D.,
Chief Medical Director.

DECEMBER 3, 1979.

STATE CLEARINGHOUSE,
Office of Economic and Community Development,
Charleston, W. Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is under consideration at the Veterans Administration Medical Center, Clarksburg, West Virginia. The estimated cost of the project is $3,500,000.

The VA Medical Center at Clarksburg is experiencing serious space and functional deficiencies in their ambulatory care, laboratory, pharmacy and radiology services. We are presently involved in the early planning for a project to provide for an addition to the main hospital in order to expand ambulatory care, outpatient pharmacy, laboratory, radiology, educational space, medical administration service, and the canteen service dining room This preliminary planning phase will develop requirements and alternative solutions which will permit a decision on the most appropriate corrective measures to be taken.

We welcome any comments developed during your coordination of this project notification and especially those of the health planning agencies which function in the northcentral West Virginia area served by this VA medical center. This includes Health Systems Agencies and the State Health Coordinating Council in accordance with A–95, Part II, paragraph 2a. A similiar letter of notification has been sent to the Areawide Clearinghouse.

Your interest in this letter is appreciated.

Sincerely,

HERBERT M. BAGANZ, M.D.,
Assistant Chief Medical Director
for Planning and Program Development.

DECEMBER 3, 1979.

REGION VI PLANNING AND DEVELOPMENT COUNCIL,
Deveny Building,
Fairmount, W. Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is under consideration at the Veterans Administration Medical Center, Clarksburg, West Virginia. The estimated cost of the project is $3,500,000.

The VA Medical Center at Clarksburg is experiencing serious space and functional deficiencies in their ambulatory care, laboratory, pharmacy and radiology services. We are presently involved in the early planning for a project to provide for an addition to the main hospital in order to expand ambulatory care, outpatient pharmacy, laboratory, radiology, educational space, medical administration service, and the canteen service dining room. This preliminary planning phase will develop requirements and alternative solutions which will permit a decision of the most appropriate corrective measures to be taken.

We welcome any comments developed during your coordination of this project notification and especially those of the health planning agencies which function in the northcentral West Virginia area served by this VA medical center. This includes Health Systems Agencies and the State Health Coordinating Council in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Your interest in this matter is appreciated.

Sincerely,

HERBERT M. BAGANZ, M.D.,
Assistant Chief Medical Director
for Planning and Program Development.

DECEMBER 26, 1979.

OFFICE OF PLANNING & PROGRAMMING,
Des Moines, Iowa

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is under consideration at the Veterans Administration Medical Center, Iowa City, Iowa. The estimated cost of the project is $11,000,000.

We are presently involved in the early planning for a project to provide for an addition to the hospital for ambulatory care, radiology, cardiac catheterization, and supply processing and distribution along with the expansion of education and research. The vacated space will be backfilled by dental service, laboratory, and pharmacy. This preliminary planning phase will develop requirements and alternative solutions which will permit a decision on the most appropriate corrective measures to be taken.

We welcome any comments developed during your coordination of this project notification and especially those of the health planning agencies which function in the southeastern Iowa and northwestern Illinois area served by this VA medical center. This includes Health Systems Agencies and the State Health Coordinating Council in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Your interest in this matter is appreciated.

Sincerely,

HERBERT M. BAGANZ, M.D.,
Assistant Chief Medical Director
for Planning and Program Development.

DECEMBER 26, 1979.

EAST CENTRAL IOWA ASSOCIATION OF RPCs,
Iowa City, Iowa

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a construction project that is under consideration at the Veterans Administration Medical Center, Iowa City, Iowa. The estimated cost of the project is $11,000,000.

We are presently involved in the early planning for a project to provide for an addition to the hospital for ambulatory care, radiology, cardiac catheterization, and supply processing and distribution along with the expansion of education and research. The vacated space will be backfilled by dental service, laboratory, and pharmacy. This preliminary planning phase will develop requirements and alternative solutions which will permit a decision on the most appropriate corrective measures to be taken.

We welcome any comments developed during your coordination of this project notification and especially those of the health planning agencies which function in the southeastern Iowa and northwestern Illinois area served by this VA medical center. This includes Health Systems Agencies and the State Health Coordinating Council in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Your interest in this matter is appreciated.

Sincerely,

HERBERT M. BAGANZ, M.D.,
Assistant Chief Medical Director
for Planning and Program Development.

Dr. BAGANZ. Just to clarify, yes we do make exceptions. The way we make exceptions on those projects that are not of this magnitude is we go through the A–95 process not identifying the fiscal year for funding. We go out for review and comment.

In this particular instance we did go out in Minneapolis with the nursing home care and the boiler plant and did receive back local favorable approval on both of those projects in 1977.

Mr. STEINBERG. At about a $10 million estimate?

Dr. BAGANZ. That's right, but we did not identify the fiscal year for funding in those letters. That's the difference.

Mr. Steinberg. Would you provide for the record the process that has been followed over the last 10 years vis-a-vis A–95 for all replacement hospital and new hospital construction?

Dr. Baganz. Yes, sir.

[Subsequently, the Veterans' Administration furnished the following information:]

Attached is a copy of M–1, Part 1, Chapter 13, "Evaluation, Review and Coordination of Federal and Federally Assisted Programs and Projects." This represents the A–95 procedures now is use.

On May 11, 1976, President Ford announced his decision to construct eight Veterans Administration hospitals at the rate of two hospitals per year. Subsequent to the announcement, A–95 notification was made to the appropriate State and Areawide Clearinghouses. Attached are copies of the letters.

Veterans Administration
Washington, D.C. 20420

MP-1, Part I
Chapter 13

May 24, 1976

1. Attached is a new Chapter 13, "Evaluation, Review and Coordination of Federal and Federally Assisted Programs and Projects," Part I, VA Manual MP-1, "General Administrative." This new chapter is issued to establish VA policies and procedures for complying with the Office of Management and Budget Circular A-95, dated January 2, 1976.

2. For your use and easy reference a copy of the OMB Circular (see App. A) is included.

3. The procedures in this chapter are effective March 12, 1976.

By direction of the Administrator:

Odell W Vaughn

ODELL W. VAUGHN
Deputy Administrator

Distribution: RPC: 0861 assigned
FD

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APPENDIX

A. Office of Management and Budget Circular A-95 . . . . 13-A1

CHAPTER 13. EVALUATION, REVIEW, AND COORDINATION OF FEDERAL AND FEDERALLY ASSISTED PROGRAMS AND PROJECTS (OMB CIRCULAR A-95)

1. PURPOSE

a. This chapter furnishes guidance to Departments of the VA for added cooperation with State and local governments in the evaluation, review and coordination of Federal development and assistance programs. These procedures provide, in part, for:

(1) Encouraging the establishment of a project notification and review system to facilitate coordinated planning on an intergovernmental basis for certain VA assistance programs in furtherance of Section 204 of the Demonstration Cities and Metropolitan Development Act of 1966 (PL 89-754) and Title IV of the Intergovernmental Cooperation Act of 1968 (PL 90-577).

(2) Coordination of direct Federal development programs and projects with State, areawide and local planning and programs pursuant to Title IV of the Intergovernmental Cooperation Act of 1968.

(3) Securing the comments and views of State and local agencies which are authorized to develop and enforce environmental standards on certain Federal or federally assisted projects affecting the environment pursuant to Section 102(2)(C) of the NEPA (National Environmental Policy Act) of 1969 (PL 91-190) and regulations of the Council on Environmental Quality.

(4) Publishing the requirement for use of Standard Form 424, Federal Assistance, as part of grant applications for designated programs.

b. The above will be carried out at the earliest feasible time in project planning. Notification will include a summary description of the project and will contain the following information, as appropriate and available:

(1) Identity of the applicant agency, organization, or individual.

(2) The geographic location of the project to be assisted or constructed. A map should be provided, if appropriate.

(3) A brief description of the proposed project by type, purpose, general size or scale, estimated cost, beneficiaries, or other characteristics which will enable the clearinghouses to identify agencies of State or local Government having plans, programs, or projects that might be affected by the proposed projects.

(4) A statement as to whether or not applicants have been advised by the VA that they will be required to submit environmental impact information in connection with the proposed project.

(5) The Federal program title and number and agency under which assistance will be sought as indicated in Attachment D of OMB Circular A-95 (revised) or the latest *Catalog of Federal Domestic Assistance*. (The *Catalog* is issued annually in the spring and is updated during the year.) *In the case of programs not listed therein, the program will be identified by Public Law Number or U.S. Code citation.*

(6) The estimated date the applicant expects to formally file an application.

2. SCOPE

These regulations are to serve as agency procedural guidelines in carrying out the provisions of OMB Circular A-95 (revised) and are applicable to the following programs identified in the Catalog of Federal Domestic Assistance.

64.005	Grants to States for Construction of State Nursing Home Care Facilities
64.017	Grants to States for Remodeling of State Home Hospital/Domiciliary Facilities
64.020	Assistance in the Establishment of New State Medical School
64.021	Grants to Affiliated Medical Schools—Assistance to Health Manpower Training Institutions
64.114	Veterans Housing—Guaranteed and Insured Loans

All activities of the VA, including those listed in the Catalog of Federal Domestic Assistance, which are applicable to the notification process under OMB Circular A-95, Part II (Direct Federal Development) are also within the purview of these regulations. This includes activities in the areas of health care delivery, construction, and cemeteries.

3. RESPONSIBILITIES

a. **Department of Medicine and Surgery.** The Department of Medicine and Surgery is responsible for agency compliance under this chapter for the following assistance programs: State Home Grant Programs 64.005 and 64.017 and Medical School Assistance Programs 64.020 and 64.021. It is the further responsibility of the Department of Medicine and Surgery to notify the State and areawide clearinghouses of planned VA construction projects related to medical facilities, changes in the delivery mode, the advent of new services and other aspects of the agency's health care program applicable to the notification process under OMB Circular A-95, Part II, as described herein. This shall be accomplished where appropriate through the DM&S designated representatives to the area Health System Agency and the State Health Coordinating Council.

b. **Office of Construction.** The Assistant Administrator for Construction is responsible for agency compliance with OMB Circular A-95, Part II, for all VA Cemetery construction projects and acquisition of real property.

c. **Department of Veterans Benefits.** The Loan Guaranty Service is responsible for agency compliance with OMB Circular A-95 for the Veterans Housing–Guaranteed and Insured Loans Program 64.114.

d. **Controller.** The Controller will act as the VA liaison with the Office of Management and Budget in matters relating to compliance with OMB Circular A-95.

e. **Department and Staff Office Heads.** Department or Staff heads will supplement this chapter as necessary to make its provisions and policies effective in their areas of jurisdiction. In carrying out these responsibilities they will seek the advice and guidance of the Chief Medical Director and Controller, as appropriate. The instructions in this chapter are effective concurrent with publication in the FEDERAL REGISTER, March 12, 1976.

4. DEFINITIONS

a. **Office of Management and Budget Circular A-95.** The instructions from the Office of Management and Budget to the heads of executive departments and establishments which promulgate regulations which provide for the coordination of Federal Assistance and Direct Federal Development programs and projects, with States and localities.

b. **Clearinghouse.** State and areawide organizations established to aid in the coordination of Federal or federally assisted projects and programs with State, areawide, and local planning for orderly growth and development. These organizations are listed in the Directory of State and Areawide A-95 Clearinghouses.

c. **Application.** A request for assistance under a Federal Assistance program.

d. **Assistance Program.** A program whereby a grant of Federal assistance is made available to non-Federal entities.

e. **Direct Development Programs.** Planning and construction of public works, physical facilities and installations or land and real property development (including the acquisition, use and disposal of real property) undertaken by or for the use of the VA or any of its Departments.

f. **Health Systems Agencies.** An area health planning organization established pursuant to the National Health Planning and Resources Development Act of 1974 (PL 93-641).

g. **State Health Planning Agencies.** An organization of State Government selected to carry out the State administrative program in the area of health planning as prescribed by the National Health Planning and Resources Development Act of 1974 (PL 93-641).

5. PROJECT NOTIFICATION AND REVIEW SYSTEM (PNRS)

a. **Assistance Programs**

(1) All entities making application for assistance under programs of the Department of Medicine and

Surgery listed below, shall include with their application a Standard Form 424, Federal Assistance, with Sections I and II completed.

(2) Standard Form 424 must contain evidence that the appropriate State and areawide planning and development clearinghouses have been given an opportunity to review and comment on said application.

(3) Those programs applicable under this requirement (identified by Title and Federal Domestic Assistance Catalog number) are:

64.005	Grants to States for construction of State Nursing Home Care Facilities.
64.017	Grants to States for Remodeling of State Home Hospital/Domiciliary Facilities.
64.020	Assistance in the Establishment of New State Medical Schools.
64.021	Grants to Affiliated Medical Schools--Assistance to Health Manpower Training Institutes.

(4) Applicant shall notify the clearinghouse of its intent to apply for assistance at such time as it determines it will develop an application.

(5) Clearinghouses will be provided 30 days after receipt of a project notification to inform those State, regional and local agencies affected. The review by the clearinghouse and affected agencies and the submission of their comments to the applicant may be completed during this 30-day period. If the review has not been completed, the clearinghouse may work with applicant in the resolution of any problems raised by the proposed project during the periods in which the application is being completed. In cases where the clearinghouse is notified by receipt of a completed application, the clearinghouse may have a maximum of 60 days to review the application. If a completed application is submitted during the first 30 days, the clearinghouse may have 30 days plus the number of days remaining in the initial 30-day notification period to complete its review. In all other cases, the clearinghouse may have 30 days to review a completed application.

(6) All comments provided to the applicant by the clearinghouse will be included with the application when presented to the agency. If no comments are received from the clearinghouse, this must be indicated on Standard Form 424 included with the application. Applications received without Section II of Standard Form 424 duly certified, or without comments from the clearinghouses when a response is indicated, will be returned to the applicant without consideration.

(7) The clearinghouse will be notified of the agency's decision on each application and an explanation of any decision contrary to the recommendation of the clearinghouse will be provided. The responsible department for programs covered by both OMB Circular A-95 and Treasury Circular 1082 will insure that for approved applications only one SF 424 award notice will be sent to those States where the address for the State Clearinghouse (A-95) and the SCIRA (TC 1082) is identical.

(8) In the event that clearinghouse comments identify project conflicts with other Federal agencies, a review of the proposal in light of the conflict will be made in consultation with other Federal agencies before a decision is made on the application for assistance.

b. Home Loan Guaranty Program

(1) Applicability

(a) The procedures herein for State and areawide clearinghouse review will be applicable to each request for subdivision approval which meets the following criteria:

1. In Urbanized Areas as defined in the U.S. Bureau of Census (see app. A, 1970 Census of Population, Characteristics of the Population or Characteristics of Housing), to

a. Subdivisions having 25 or more lots, including horizontal condominium subdivisions having 25 or more dwelling units;

b. Multifamily (low rise and high rise) condominium projects having 50 or more dwelling units;

c. Mobile home sales parks or subdivisions with 50 or more spaces.

2. In all other areas, to

a. Subdivision having 10 or more lots, including horizontal condominium subdivisions having 10 or more dwelling units;

b. Multifamily (low rise and high rise) condominium projects having 25 or more dwelling units;

c. Mobile home sales parks or subdivisions with 25 or more spaces.

(b) As an alternative, the developer may submit his application directly to the appropriate clearinghouse prior to submitting it to the VA . In such cases the application, when submitted to the VA, will be accompanied by the comments of the clearinghouse.

(c) Exemptions: Applications for additional units in a subdivision substantially completed (*i.e.*, with streets, water and sewer facilities, culverts, etc.) are exempted from this requirement when

1. The subdivision was approved and/or recorded by the appropriate unit of local Government within 3 years of the application submittal; and

2. In all cases of subdivisions approved more than 3 years prior, the clearinghouses waive the requirement. This exemption does not apply to applications for housing in an undeveloped subdivision or in proposed extensions of existing subdivisions.

(d) For the purpose of determining the applicability of the instructions herein, the number of units planned, rather than the total units in the subdivision or project request, will govern.

(2) **Coordination of request for subdivision approvals**

(a) Field stations will establish and maintain liaison with clearinghouses for carrying out the reviews by this issue. On receipt of a request for subdivision approval meeting the criteria specified above, field stations will use FL 26-616 to forward a copy of VA Form 26-8492, Application for Subdivision Feasibility Analysis (ASP-1), together with a location map, to the appropriate clearinghouses (in accordance with OMB Directory of State and Areawide A-95 Clearinghouses). Clearinghouses will be afforded 30 calendar days to review the application and to forward to VA any comments which they may have, including observations concerning the consistency of the proposed project with State and areawide development plans, the extent to which the proposed project will promote housing opportunities for all segments of the community and identification of major environmental concerns including impact on energy resource supply and demand.

(b) Pending receipt of comments from clearinghouses, VA will pursue its own independent assessment, and requests for subdivision approval will continue to be processed by field stations up to and including the preparation of VA Form 26-8492b, Subdivision Feasibility Valuation Report (ASP-3), stage.

(c) If comments have not been received from a clearinghouse by the end of the 30 calendar-day period, the station will then and thereafter consider that the clearinghouse has no objection to the subdivision. However, if clearinghouse comments are received after the 30-day period, but before the field station has notified the sponsor that the site or project is feasible (through release of VA Form 26-8492d, Interim Report on Application for Subdivision Feasibility Analysis (ASP-5), or FL 26-603 (ASP-6), the clearinghouse comments will be considered.

(3) **Procedure**

(a) When the comments of the State and areawide clearinghouse are received, or in the event such comments are not received at the end of the 30 days allotted for review, the field station will evaluate all the available data, including the views of the clearinghouse, where appropriate, in order to determine whether or not the subdivision will result in a significant environmental impact. The determination is an independent VA assessment and must be fully documented by the completion of VA Form 26-8492b. Thus it will be that each request for subdivision approval will come within one of four categories, viz–

1. A determination by the field station of no significant environmental impact, based on the determination during VA processing, coupled with no adverse comments from clearinghouses.

2. A determination by the field station of no significant environmental impact, based on the determination during VA processing, but the clearinghouses disagree.

3. A determination by the field station that the subdivision will result in a significant environmental impact, based on the determination during VA processing, but the comments from clearinghouses do not afford a basis for the same conclusion.

4. A determination by the field station that the subdivision will result in a significant environmental impact, based on the determination during VA

processing, coupled with comments to the same effect from clearinghouses.

(b) Each case in category 1 will be processed to completion as rapidly as possible, with a notification of approval promptly issued using FL 26-615. In respect to each case in categories 2, 3 or 4, the field station will promptly notify the person or firm submitting the request for subdivision approval about the determination, using FL 26-615. Such person or firm will be invited to consult with the field station or the clearinghouses, as appropriate, with the view to the amendment or revision of the subdivision plan so as to render the planning of the subdivision to be acceptable.

(c) Where the person or firm submitting the request for subdivision approval provides amended or revised plans, a letter of approval may be issued only if the following conditions are met:

1. Category 2. Evidence is supplied or obtained that the State and areawide clearinghouses find the subdivision acceptable.

2. Category 3. The field station, on the basis of amended or revised subdivision plans, determines that the subdivision will not result in significant environmental impact.

3. Category 4. The field station, on the basis of amended or revised subdivision plans, determines that the subdivision will not result in an adverse environmental impact and evidence is supplied or obtained that the State and areawide clearinghouses find the subdivision acceptable.

(d) In all instances clearinghouses will be provided with a copy of the notification of approval or disapproval of the site or subdivision. Copies of VA Forms 26-8492c, Final Report on Application for Subdivision Feasibility Analysis (ASP-4), 26-8493d, or FL 26-603, will be used for the purpose of notifying the clearinghouses of the action taken by VA. Where a State clearinghouse has assigned an identification number to an application, such number will be used in notifying the clearinghouse.

(e) Where a clearinghouse recommends against approval on an application or approval with specific and major substantive changes, and the field station approves the subdivision as submitted without the recommended changes the clearinghouse will be provided with a written explanation.

6. DIRECT FEDERAL DEVELOPMENT

a. To the greatest extent possible consistent with the statutory mission of the VA to provide Federal health care benefits to eligible veterans, the agency will follow procedures outlined under Part I of Attachment A, OMB Circular A-95 (revised) in affording State and areawide clearinghouses opportunities to review and comment on plans and developments.

b. The appropriate clearinghouses will be provided, for review and comment, information on agency plans for facility construction projects and the acquisition or use of Federal land and real property which impacts on States and localities to assure maximum feasible consistency of agency plans with State, areawide, and local plans and programs. This coordination will also provide the agency with information on possible environmental impact of the proposed development. Agency plans for the provision of major new medical care services will be coordinated in like manner.

c. The coordination with clearinghouses will take place at the earliest stage practical in the planning and design process.

d. **Criteria for Notification.** A project will be reported to State and areawide clearinghouses provided that it is any of the following:

(1) A building addition or new structure. (Minor utility pads or equipment and projects for additions, alteration, or modernization of an existing facility which do not substantially alter the scale or the type or intensity of use of such facility need not be reported.)

(2) A cemetery burial area expansion of 20 acres or more.

(3) A major utility modernization that may require new primary power sources from the community.

(4) A project affecting any historic VA building or site which is a present or potential National Register property.

(5) An acquistion of real property.

(6) A major building demolition project exceeding $200,000 expenditure.

(7) A project for inpatient care purposes exceeding $200,000 expenditure and either

(a) alters the bed capacity by 25,

(b) modifies the primary function of the facility, or

(c) provides a major new medical care service e.g., Supervoltage Therapy, Hemodialysis, Cardiac Catheterization, etc.

e. The clearinghouse will be provided a maximum of 60 days to coordinate the review among appropriate Health System Agencies, State Health Planning Agencies and other affected agencies and make comment on the proposed project.

f. The responsible department will notify the clearinghouse in writing when taking action contrary to the clearinghouse recommendation submitted. Explanation will be provided for any necessary inconsistency or incompatibility.

g. Those projects for which clearinghouse notification has been performed and which have subsequent schedule changes in excess of 1 year, will be resubmitted to the clearinghouses.

h. Coordination With Environmental Impact Program

(1) Environmental Impact 102 Statements are normally prepared for the following categories of VA action

(a) Any major land acquisition and improvement thereon.

(b) A major new building or facility is constructed at an existing facility or site and the new building or facility will have significantly adverse environmental impact in relation to the existing facility or site.

(c) A major replacement building or facility is constructed at an existing facility and the adverse environmental impact of the replacement building or facility is greater than that of the building or facility being replaced.

(2) When the Assistant Chief Medical Director for Administration (13) has approved the need for a 102 Statement on a particular VA construction project, the responsible office preparing the Statement (Assistant Administrator for Construction) will request copies of clearinghouse comments from the Department of Medicine and Surgery to include in the Draft 102 Statement.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. [illegible]

January 2, 1976

CIRCULAR NO. A-95
Revised

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Evaluation, review, and coordination of Federal and federally assisted programs and projects

1. Purpose. This Circular furnishes guidance to Federal agencies for cooperation with State and local governments in the evaluation, review, and coordination of Federal and federally assisted programs and projects. The Circular promulgates regulations (Attachment A) which provide, in part, for:

a. Encouraging the establishment of a project notification and review system to facilitate coordinated planning on an intergovernmental basis for certain Federal assistance programs in furtherance of section 204 of the Demonstration Cities and Metropolitan Development Act of 1966 and Title IV of the Intergovernmental Cooperation Act of 1968 (Attachment B).

b. Coordination of direct Federal development programs and projects with State, areawide, and local planning and programs pursuant to Title IV of the Intergovernmental Cooperation Act of 1968.

c. Securing the comments and views of State and local agencies which are authorized to develop and enforce environmental standards on certain Federal or federally assisted projects affecting the environment pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969 (Attachment (C)) and regulations of the Council on Environmental Quality.

d. Furthering the objectives of Title VI of the Civil Rights Act of 1964.

This Circular supersedes Circular No. A-95 (Revised), dated November 13, 1973 (Part II, Federal Register, Vol. 38, No.

228, pp. 32874-32881, November 28, 1973). It will become effective February 27, 1976.

2. Basis. This Circular has been prepared pursuant to:

a. Section 401(a) of the Intergovernmental Cooperation Act of 1968 which provides, in part, that

> "The President shall . . . establish rules and regulations governing the formulation, evaluation, and review of Federal programs and projects having a significant impact on area and community development..."

and the President's Memorandum of November 8, 1968, to the Director of the Bureau of the Budget ("Federal Register," Vol. 33, No. 221, November 13, 1968) which provides:

> "By virtue of the authority vested in me by section 301 of title 3 of the United States Code and section 401(a) of the Intergovernmental Cooperation Act of 1968 (Public Law 90-577), I hereby delegate to you the authority vested in the President to establish the rules and regulations provided for in that section governing the formulation, evaluation, and review of Federal programs and projects having a significant impact on area and community development, including programs providing Federal assistance to the States and localities, to the end that they shall most effectively serve these basic objectives.
>
> "In addition, I expect the Bureau of the Budget to generally coordinate the actions of the departments and agencies in exercising the new authorizations provided by the Intergovernmental Cooperation Act, with the objective of consistent and uniform action by the Federal Government."

b. Title IV, section 403, of the Intergovernmental Cooperation Act of 1968 which provides that:

> "The Bureau of the Budget or such other agency as may be designated by the President, is hereby authorized to prescribe such rules and regulations as are deemed appropriate for the effective administration of this Title."

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c. Section 204(c) of the Demonstration Cities and Metropolitan Development Act of 1966 which provides that:

> "The Bureau of the Budget, or such other agency as may be designated by the President, shall prescribe such rules and regulations as are deemed appropriate for the effective administration of this section," and

d. Reorganization Plan No. 2 of 1970 and Executive Order No. 11541 of July 1, 1970, which vest all functions of the Bureau of the Budget or the Director of the Bureau of the Budget in the Director of the Office of Management and Budget.

3. Coverage. The regulations promulgated by this Circular (Attachment A) will have applicability:

a. Under Part I, to all projects and activities (or significant substantive changes thereto) for which Federal assistance is being sought under the programs listed in Attachment D or Appendix I of the Catalog of Federal Domestic Assistance whichever bears the later date. Limitations and provisions for exceptions are noted therein or under paragraph 8 of Part I.

b. Under Part II, to all direct Federal development activities, including the acquisition, use, and disposal of Federal real property; in addition, agencies responsible for granting licenses and permits for developments or activities significantly affecting area and community development or the physical environment are strongly urged to consult with clearinghouses on applications for such licenses or permits.

c. Under Part III, to all Federal programs as listed in Appendix II of the Catalog of Federal Domestic Assistance, requiring, by statute or administrative regulation, a State plan as a condition of assistance.

d. Under Part IV, to all Federal programs providing assistance to State, areawide, or local agencies or organizations for multijurisdictional or areawide planning.

4. "A-95: What It Is - How It Works." A fuller discussion of the background, purposes, and objectives of the Circular and of the requirements promulgated thereunder may be found in the brochure, "A-95: What It Is - How It Works,"

obtainable from the Office of Management and Budget or from Federal Regional Councils.

5. "A-95 Administrative Notes." From time to time OMB will issue "A-95 Administrative Notes" providing interim determinations or interpretations on matters of national scope relating to administration of the Circular.

6. Federal Regional Councils. Federal Regional Councils are responsible for coordinating the implementation of the requirements of this Circular at the Federal regional level. The Office of Management and Budget is responsible for policy oversight of the Circular and liaison with departmental and agency liaison officers on matters of national scale related to the requirements of the Circular.

7. Federal agency implementing procedures and regulations. Agencies will develop interim procedures and regulations implementing the requirements of this Circular revision which will become effective on February 27, 1976. The interim procedures and regulations will be published in the Federal Register no later than February 27, 1976. Agencies will promulgate final implementing procedures and regulations no later than April 29, 1976. OMB will assist and cooperate with agencies in developing such procedures and regulations.

8. Inquiries. Inquiries concerning this Circular may be addressed to the Regional A-95 Coordinator for th appropriate Federal Regional Council or to the Office of Management and Budget, Washington, D.C. 20503, telephone (202)-395-3031.

JAMES T. LYNN
DIRECTOR

Attachments

ATTACHMENT A
Circular No. A-95
Revised

REGULATIONS UNDER SECTION 204 OF THE DEMONSTRATION CITIES AND METROPOLITAN DEVELOPMENT ACT OF 1966, TITLE IV OF THE INTERGOVERNMENTAL COOPERATION ACT OF 1968, AND SECTION 102(2)(C) OF THE NATIONAL ENVIRONMENTAL POLICY ACT OF 1969

PART I: PROJECT NOTIFICATION AND REVIEW SYSTEM

1. Purpose. The purpose of this Part is to:

a. Further the policies and directives of Title IV of the Intergovernmental Cooperation Act of 1968 by encouraging the establishment of a network of State and areawide planning and development clearinghouses which will aid in the coordination of Federal or federally assisted projects and programs with State, areawide, and local planning for orderly growth and development.

b. Implement the requirements of section 204 of the Demonstration Cities and Metropolitan Development Act of 1966 for metropolitan areas within that network.

c. Implement, in part, requirements of section 102(2)(C) of the National Environmental Policy Act of 1969, which require that State, areawide, and local agencies which are authorized to develop and enforce environmental standards be given an opportunity to comment on the environmental impact of Federal or federally assisted projects.

d. Provide public agencies charged with enforcing or furthering the objectives of State and local civil rights laws with opportunity to participate in the review process established under this Part.

e. Encourage, by means of early contact between applicants for Federal assistance and State and local governments and agencies, an expeditious process of intergovernmental coordination and review of proposed projects.

2. Notification of Intent.

a. Any agency of State or local government or any organization or individual undertaking to apply for assistance to a project or major substantive modification thereto under a Federal program covered by this Part will be required to notify both the State and areawide planning and development clearinghouse in the jurisdiction of which the project is to be located of its intent to apply for assistance at such time as it determines it will develop an application.

In the case of applications for projects involving land or water use and development or construction in the National Capital Region (as defined in section 1(b) of the National Capital Planning Act of 1952, as amended) a copy of the notification will be sent to the National Capital Planning Commission (NCPC) in addition to the areawide clearinghouse and the appropriate State clearinghouse. NCPC is the official planning agency for the Federal Government in the National Capital Region.

In the case of an application in any State for an activity that is Statewide or broader in nature (such as for various types of research) and does not affect nor have specific applicability to areawide or local planning and programs, the notification need be sent only to the State clearinghouse. Involvement of areawide clearinghouses i the review in such cases will be at the initiative of th State clearinghouse.

Notifications will include a summary description of the project for which assistance will be sought. The summary description will contain the following information, as appropriate and to the extent available:

(1) Identity of the applicant agency, organization, or individual.

(2) The geographic location of the project to be assisted. A map should be provided, if appropriate.

(3) A brief description of the proposed project by type, purpose, general size or scale, estimated cost, beneficiaries, or other characteristics which will enable the clearinghouses to identify agencies of State or local

government having plans, programs, or projects that might be affected by the proposed projects.

(4) A statement as to whether or not the applicant has been advised by the funding agency from which assistance is being sought that he will be required to submit environmental impact information in connection with the proposed project.

(5) The Federal program title and number and agency under which assistance will be sought as indicated in Attachment D or the latest Catalog of Federal Domestic Assistance. (The Catalog is issued annually in the spring and is updated during the year.) In the case of programs not listed therein, programs will be identified by Public Law number or U.S. Code citation.

(6) The estimated date the applicant expects to formally file an application.

Many clearinghouses have developed notification forms and instructions. Applicants are urged to contact their clearinghouses for such information in order to expedite clearinghouse review.

b. In order to assure maximum time for effective coordination and so as not to delay the timely submission of the completed application to the funding agency, notifications containing the preliminary information indicated above should be sent at the earliest feasible time.

c. Applications from federally recognized Indian tribes are not subject to the requirements of this Part. However, Indian tribes may voluntarily participate in the Project Notification and Review System and are encouraged to do so. Federal agencies will notify the appropriate State and areawide clearinghouses of any applications from federally recognized Indian tribes upon their receipt. Where a federally recognized Tribal Government has established a mechanism for coordinating the activities of Tribal departments, divisions, enterprises, and entities, Federal agencies will, upon request of such Tribal Government transmitted through the Office of Management and Budget, require that applications for assistance under programs covered by this Part from such Tribal departments, divisions, enterprises, and entities be subject to review by such Tribal coordinating mechanism as though it were a State or areawide clearinghouse.

3. Clearinghouse functions. Clearinghouse functions include:

a. Evaluating the significance of proposed Federal or federally assisted projects to State, areawide, or local plans and programs.

b. Receiving and disseminating project notifications to appropriate State and multistate agencies in the case of the State clearinghouse and to appropriate local governments and agencies and regional organizations in the case of areawide clearinghouses; and providing liaison, as may be necessary, between such agencies or bodies and the applicant. In the case of units of general local government, notifications of all projects affecting his jurisdiction will, if requested, be sent to the chief executive of such unit by the areawide clearinghouse or to such central agency as he may designate for review and reference to appropriate agencies of such unit.

c. In the case of projects under programs covered by this Part located in the coastal zone, as defined in the Coastal Zone Management Act of 1972, assuring that the State agency, if other than the State clearinghouse, responsible for administration of the approved program for the management of the coastal zone, is given opportunity to review the project for its relationship to such program and its consistency therewith.

d. Assuring, pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969, that appropriate State, multistate, areawide, or local agencies which are authorized to develop and enforce environmental standards are informed of and are given opportunity to review and comment on the environmental significance of proposed projects for which Federal assistance is sought.

e. Providing public agencies charged with enforcing or furthering the objectives of State and local civil rights laws with opportunity to review and comment on the civil rights aspects of the project for which assistance is sought.

f. Providing, pursuant to Part II of these regulations, liaison between Federal agencies contemplating direct Federal development projects and the State or areawide agencies or local governments having plans or programs that might be affected by the proposed project.

g. In the case of a project for which Federal assistance is sought by a special purpose unit of local government, clearinghouses will assure that any unit of general local government having jurisdiction over the area in which the project is to be located has opportunity to confer, consult, and comment upon the project and the application.

h. Where areawide clearinghouse jurisdictions are contiguous, coordinative arrangements should be established between the clearinghouses in such areas to assure that projects in one area which may have an impact on the development of a contiguous area are jointly studied. Any comments and recommendations made by or through a clearinghouse in one area on a project in a contiguous area will accompany the application for assistance to that project.

4. Consultation and review.

a. State and areawide clearinghouses may have a period of 30 days after receipt of a project notification in which to inform State and multistate agencies and local or regional governments or agencies (including agencies referred to in subparagraphs c, d, and e, above) that may be affected by the proposed project and arrange, as may be necessary, to consult with the applicant thereon. The review may be completed in this period and comments may be submitted to the applicant.

b. If the review is not completed during this period, the clearinghouse may work with the applicant in the resolution of any problems raised by the proposed project during the period in which the application is being completed.

c. In cases where no project notification has been submitted and the clearinghouse receives only a completed application, it may have 60 days to review the completed application. If a completed application is submitted during the first 30 days after a notification has been submitted, the clearinghouse may have 30 days plus the number of days remaining in the initial 30 day notification period to complete its review. In all other cases, the clearinghouse may have 30 days to review a completed application. Where clearinghouses have not completed their reviews during the 30 day notification period, they are strongly urged to give the applicant formal notice to that effect. Where reviews have been completed prior to completion of an application, an information copy will be supplied to the clearinghouse, upon request, when the application is submitted to the funding agency.

d. Written comments submitted to the areawide clearinghouse by other jurisdictions, agencies, or parties will be included as attachments to the comments of areawide clearinghouses, when they are at variance with the clearinghouse comments; and others from whom comments were solicited and received should be listed.

e. Under some programs, applicants - primarily non-governmental - are required to submit confidential information to the funding agency. Such information may relate to the applicant's financial status or structure (e.g., overall investment program or holdings); to personnel (e.g., personal histories of project officers) or may involve proprietary information (e.g., industrial processes, research ideas). Such confidential information need not be included with applications submitted to clearinghouses fo review.

f. Applicants will include with the completed application as submitted to the Federal agency (or to the State agency in the case of projects for which the State, under certain programs, has final project approval):

(1) All comments and recommendations made by or through clearinghouses, along with a statement that such comments have been considered prior to submission of the application; or

(2) Where no comments have been received from a clearinghouse, a statement that the procedures outlined in this section have been followed and that no comments or recommendations have been received.

g. Applications for renewal or continuation grants or applications not submitted to or acted on by the funding agency within one year after completion of clearinghouse review will be subject to re-review upon request of the clearinghouse.

5. Subject matter of comments and recommendations. Comments and recommendations made by or through clearinghouses with respect to any project are for the purpose of assuring maximum consistency of such project with State, areawide, and local comprehensive plans. They are also intended to assist the Federal agency (or State agency, in the case of projects for which the State under certain Federal grants has final project approval) administering such a program in determining whether the project is in accord with applicable Federal law, particularly those requiring consistency with State, areawide, or local plans. Comments or recommendations may include, but need not be limited to, information about:

a. The extent to which the project is consistent with or contributes to the fulfillment of comprehensive planning for the State, area, or locality.

b. The extent to which the proposed project:

(1) Duplicates, runs counter to, or needs to be coordinated with other projects or activities being carried out in or affecting the area; or

(2) Might be revised to increase its effectiveness or efficiency in relationship to other State, area, or local programs and projects.

c. The extent to which the project contributes to the achievement of State, areawide, and local objectives and priorities relating to natural and human resources and economic and community development as specified in section 401 of the Intergovernmental Cooperation Act of 1968, including:

(1) Appropriate land uses for housing, commercial, industrial, governmental, institutional, and other purposes;

(2) Wise development and conservation of natural resources, including land, water, mineral, wildlife, and others;

(3) Balanced transportation systems, including highway, air, water, pedestrian, mass transit, and other modes for the movement or people and goods;

(4) Adequate outdoor recreation and open space;

(5) Protection of areas of unique natural beauty, historical and scientific interest;

(6) Properly planned community facilities, including utilities for the supply of power, water, and communications, for the safe disposal of wastes, and for other purposes; and

(7) Concern for high standards of design.

d. As provided under section 102(2)(C) of the National Environmental Policy Act of 1969, the extent to which the project significantly affects the environment including consideration of:

(1) The environmental impact of the proposed project;

(2) Any adverse environmental effects which cannot be avoided should the proposed project be implemented;

(3) Alternatives to the proposed project;

(4) The relationship between local short term uses of man's environment and the maintenance and enhancement of long term productivity; and

(5) Any irreversible and irretrievable commitments of resources which would be involved in the proposed project or action, should it be implemented.

e. Effects on energy resource supply and demand.

f. The extent to which people or businesses will be displaced and the availability of relocation resources.

g. As provided under section 307(d) of the Coastal Zone Management Act of 1972, in the case of a project located in the coastal zone, the relationship of the project to the approved State program for the management of the coastal zone and its consistency therewith.

(No. A-95)

h. The extent to which the project contributes to more balanced patterns of settlement and delivery of services to all sectors of the area population, including minority groups.

i. In the case of a project for which assistance is being sought by a special purpose unit of local government, whether the unit of general local government having jurisdiction over the area in which the project is to be located has applied, or plans to apply, for assistance for the same or a similar type project. This information is necessary to enable the Federal (or State) agency to make the judgments required under section 402 of the Intergovernmental Cooperation Act of 1968.

6. Federal agency procedures. Federal agencies having programs covered under this Part will develop appropriate procedures for:

a. Informing potential applicants for assistance under such programs of the requirements of this Part (1) in program information materials, (2) in response to inquiries respecting application procedures, (3) in pre-application conferences, or (4) by other means which will assure earliest contact between applicant and clearinghouses.

b. Assuring that all applications for assistance under programs covered by this part have been submitted to appropriate clearinghouses for review prior to their submission to the funding agency. Applications that do not carry evidence that both areawide and State clearinghouses have been given an opportunity to review the application will be returned to the applicant with instructions to fulfill the requirements of this Part. Agencies will insure that all applications contain a State Application Identifier (SAI) number. (This is mandatory for use in notifying clearinghouses of action taken on the application.)

c. Notifying such clearinghouses within seven working days of any major action taken on such applications that have been reviewed by said clearinghouses. Major actions will include awards, rejections, returns for amendment, deferrals, or withdrawals. The standard multipurpose form, SF 424, promulgated by Federal Management Circular 74-7, will be used for this purpose, unless a waiver has been granted by OMB. (See Attachment E.)

d. Where a clearinghouse has recommended against approval of an application or approval only with specific and major substantive changes, and the funding agency approves the application substantially as submitted, the funding agency will provide the clearinghouse, along with the action notice, an explanation therefor.

e. Where a clearinghouse has recommended against approval of a project because it conflicts with or duplicates another Federal or federally assisted project, the funding agency will consult with the agency assisting the referenced projects prior to acting, if it plans to approve the application.

f. Assuring, in the case of an application submitted by a special purpose unit of local government, where accompanying comments indicate that the unit of general local government having jurisdiction over the area in which the project is to be located has submitted or plans to submit an application for assistance for the same or a similar type project, that appropriate considerations and preferences as specified in section 402 of the Intergovernmental Cooperation Act of 1968, are accorded the unit of general local government. Where such preference cannot be so accorded, the agency shall supply, in writing, to the unit of general local government and the Office of Management and Budget its reasons therefor.

7. Housing Programs. For housing programs of the Department of Housing and Urban Development, the Veterans Administration, and the Farmers Home Administration of the Department of Agriculture the following procedures will be followed, except as provided in subparagraph d below:

a. The appropriate HUD, VA, or USDA/FHA office will transmit to the appropriate State and areawide clearinghouses a copy of the initial application for project approval.

b. Clearinghouses will have 30 days from receipt to review the applications and to forward to the HUD, VA, or USDA/FHA office any comments which they may have, including observations concerning the consistency of the proposed project with State and areawide development plans, the extent to which the proposed project will provide housing opportunities for all segments of the community, and identification of major environmental concerns including impact on energy resource supply and demand. Processing of applications in the HUD, VA, or USDA/FHA office will proceed concurrently with the clearinghouse review.

c. This procedure will include only applications involving new construction or substantial rehabilitation and will apply to applications for loans, loan guarantees, mortgage insurance, or other housing assistance:

(1) In Urbanized Areas, as defined by the U.S. Bureau of the Census (see Appendix A, 1970 Census of Population, Characteristics of the Population or Characteristics of Housing), to:

(a) Subdivisions having 25 or more lots.

(b) Multifamily projects having 50 or more dwelling units.

(c) Mobile home courts with 50 or more spaces.

(d) College housing provided under the debt service or direct loan programs for 200 or more students.

(2) In all other areas, to:

(a) Subdivisions having 10 or more lots.

(b) Multifamily projects having 25 or more dwelling units.

(c) Mobile home courts with 25 or more spaces.

(d) College housing provided under the debt service or direct loan programs for 100 or more students.

d. As an alternative to the above procedure, the developer may submit his application directly to the appropriate clearinghouses prior to submitting it to the Federal agency. In such cases, the application, when submitted to the Federal agency, will be accompanied by the comments of the clearinghouses.

e. Exemption: Applications for additional units in a subdivision substantially completed (i.e., with streets, water and sewer facilities, culverts, etc.) are exempted from this requirement when:

(1) The subdivision was approved and/or recorded by the appropriate unit of local government within three years of the application submittal; and

(2) In cases of subdivisions approved more than three years prior, the clearinghouses waive the requirement.

This exemption does not apply to applications for housing in an undeveloped subdivision or in proposed extensions of existing subdivisions.

8. Coverage, exceptions, and variations.

a. Generally, this Part of this Circular and the laws on which it is based are concerned with programs providing financial assistance to projects and activities which have an impact on State, areawide, and local development, including development of natural, economic, and human resources. This Part is concerned with achieving the most effective and efficient utilization of Federal assistance programs through coordination among and between Federal, multistate, State, areawide, and local plans and programs and the elimination of conflict, overlap, and duplication of projects and activities under such programs. Coverage under this Part includes, or will be extended from time to time as deemed necessary and practicable to include programs bearing upon these concerns and objectives.

b. Programs not considered appropriate to this Part are programs of the following types:

(1) Direct financial assistance to individuals or families for housing, welfare, health care services, education, training, economic improvement, and other direct assistance for individual and family enhancement.

(2) Incentive payments or insurance for private sector activities not involving real property development or land use and development.

(3) Agricultural crop supports or payments.

(4) Assistance to organizations and institutions for the provision of education or training not designed to meet the needs of specific individual States or localities.

(5) Research, not involving capital construction, which is national in scope or is not designed to meet the needs or to address problems of a particular State, area, or locality (except in the case of demonstration or pilot research programs where projects may have an impact on the community or area in which they are being conducted).

(6) Assistance to educational, medical, or similar service institutions or agencies for internal staff development or management improvement purposes.

(7) Assistance to educational institutions for activities that are part of a school's regular academic program and are not related to local programs of health, welfare, employment, or other social services.

(8) Assistance for construction involving only routine maintenance, repair, or minor construction which does not change the use or the scale or intensity of use of the structure or facility.

c. OMB will consider Federal agency requests for exemption of certain classes of projects or activities under programs otherwise covered which:

(1) Meet any of the above characteristics of programs inappropriate for coverage under this Part;

(2) Are of small scale or size or are highly localized as to impact; or

(3) Display other characteristics which might make review impractical.

d. OMB will consider Federal agency requests for procedural variations from normal review processes:

(1) On a temporary basis for programs with time constraints brought about because of start up requirements or other unusual circumstances beyond the control of the funding agency. (Note: Delay in fund availability is not normally an acceptable reason for a variation. When a delay is anticipated, applicants should be instructed to have their applications reviewed by clearinghouses in readiness for submission when funds become available).

(2) For programs where statutory or related procedural limitations make the normal review processes impracticable.

e. All requests from Federal agencies for exemptions or procedural variations should be addressed to the Associate Director for Management and Operations, Office of Management and Budget.

f. Individual clearinghouses may exempt certain types of projects from review for reasons indicated above or for other reasons appropriate to the State or area.

g. Applicants should be made aware that, in various States, State law requires review of applications for Federal assistance under various programs not covered by this Part. Implementation of such laws is enforced through State rules and regulations, and applicants are urged to ascertain the existence of such laws and to acquaint themselves with applicable State procedures.

9. Joint Funding. Applications for assistance to activities under the Joint Funding Simplification Act (P.L. 93-510) or any other joint funding authority, which involve activities funded under one or more of the programs covered under this Part, will be subject to the requirements of this Part.

10. Agency procedures and regulations.

a. Proposed agency procedures and regulations for implementing the requirements of this Part will be published in the Federal Register as specified in paragraph 7 of this Circular. Programs to which the procedures and regulations will apply will be cited by their numbers in the Catalog of Federal Domestic Assistance. Where such numbers have not yet been assigned, programs will be referenced by Public Law and section or by U.S. Code citation. Subsequent amendments to such procedures and regulations will also be published pursuant to paragraph 7 of the Circular.

b. As a part of such proposed procedures and regulations published in the Federal Register, agencies may identify specific types of projects which they believe should be exempt from coverage under programs for which proposed procedures and regulations are being published. Such publication will constitute a formal request for exemption to the Office of Management and Budget, to which it will respond in its review of the proposed procedures and regulations.

c. OMB will assist and cooperate with agencies in developing such procedures and regulations.

d. A copy of agency internal procedures for implementation of this Part, if not contained in the above procedures and regulations, will be sent to the Associate Director of the Office of Management and Budget for Management and Operations.

11. Reports and directories.

a. The Director of the Office of Management and Budget may require reports, from time to time, on the implementation of this Part.

b. The Office of Management and Budget will maintain and distribute to appropriate Federal agencies a directory of State and areawide clearinghouses.

c. The Office of Management and Budget will notify Federal Regional Councils, clearinghouses, and Federal agencies of any excepted categories of projects under covered programs.

PART II: DIRECT FEDERAL DEVELOPMENT

1. Purpose. The purpose of this Part is to:

a. Provide State and local government with information on projected Federal development so as to facilitate coordination with State, areawide, and local plans and programs.

b. Provide Federal agencies with information on the relationship of proposed direct Federal development projects and activities to State, areawide, and local plans and programs; and to assure maximum feasible consistency of Federal developments with State, areawide, and local plans and programs.

c. Provide Federal agencies with information on the possible impact on the environment of proposed Federal development.

2. Coordination of direct Federal development projects with State, areawide, and local development.

a. Federal agencies having responsibility for the planning and construction of Federal buildings and installations or other Federal public works or development or for the acquisition, use, and disposal of Federal land and real property will establish procedures for:

(1) Consulting with Governors, State and areawide clearinghouses, and local elected officials at the earliest practicable stage in project or development planning on the relationship of any plan or project to the development plans and programs of the State, area, or locality in which the project is to be located. In the case of projects in the National Capital Region, such consultation should be undertaken in cooperation with the National Capital Planning Commission.

(2) Assuring that any such Federal plan or project is consistent or compatible with State, areawide, and local development plans and programs identified in the course of such consultations. Exceptions will be made only where there is clear justification. Explanation of any necessary inconsistency or incompatibility will be provided, in writing, to the appropriate clearinghouses.

(3) Providing State, areawide, and local agencies which are authorized to develop and enforce environmental standards with adequate opportunity to review such Federal plans and projects pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969. Any comments of such agencies will accompany the environmental impact statement submitted by the Federal agency.

(4) Providing, in the case of projects located in the coastal zone, the State agency responsible for administration of the approved program for the management of the coastal zone with opportunity to review the relationship of the proposed project to such program and its consistency therewith.

(5) Providing, through the appropriate clearinghouses, Health Systems Agencies and State Health Planning and Development Agencies designated pursuant to the National Health Planning and Resources Development Act of 1974 with adequate opportunity to review Federal projects for construction and/or equipment involving capital expenditures exceeding $200,000 for modernization, conversion, and expansion of Federal inpatient care facilities, which alter the bed capacity or modify the primary function of the facility, as well as plans for provision of major new medical care services. (Excluded are projects to renovate or install mechanical systems, air conditioning systems, or other similar internal system modifications.) The agencies are expected to evaluate proposed Federal projects for consistency with areawide and local health delivery plans and health supply-demand situations, as well as considering clearinghouse comments on such specific points as those listed in paragraph 5 of Part I. The comments of such agencies and any clearinghouse comments will accompany the plan and budget requests submitted by the Federal agency to the Office of Management and Budget or a certification that the agencies and clearinghouses had been provided a reasonable time to comment and had failed to do so.

3. Use of clearinghouses. The State and areawide planning and development clearinghouses established pursuant to Part I will be utilized to the greatest extent practicable to effectuate the requirements of this Part. Agencies are urged to establish early contact with clearinghouses to work out arrangements for carrying out the consultation and review required under this Part, including identification of types of projects considered appropriate for consultation

and review. Clearinghouses may utilize criteria set forth in paragraph 5 of Part I in evaluating direct Federal development projects.

4. Federal licenses and permits. Agencies responsible for granting Federal licenses and permits for development projects and activities which would have a significant impact on State, interstate, areawide, or local development plans or programs or on the environment are strongly urged to consult with State and areawide clearinghouses and to seek their evaluations of such impacts prior to granting such licenses or permits.

5. Agency procedures and regulations.

a. To the greatest extent possible, agencies engaged in direct Federal development activities will follow the general procedures outlined under Part I of Attachment A in affording State and areawide clearinghouses opportunities to review and comment on plans and developments.

b. Where legislative or executive constraints or related circumstances do not permit following such procedures, agency procedures and regulations will set forth for each program, at a minimum:

(1) The point in project planning at which clearinghouses will be contacted;

(2) The minimum time clearinghouses will be afforded to review the proposed project;

(3) The minimum information to be provided to the clearinghouses; and

(4) Procedures for notifying clearinghouses on actions taken on such project (implementation, timing, postponement, abandonment) and explaining actions taken contrary to clearinghouse recommendations.

c. The Office of Management and Budget will consider other procedures such as memoranda of agreement between Federal installations and clearinghouses for coordinating Federal and civilian planning, that are designed to achieve the objectives of this Part.

d. All proposed agency procedures and regulations to implement this Part will be published in the Federal Register pursuant to paragraph 7 of the Circular. OMB will assist and cooperate with agencies in developing such procedures and regulations.

PART III: STATE PLANS

1. Purpose. The purpose of this Part is to provide Federal agencies with information about the relationship to State or areawide comprehensive planning of State plans which are required or form the basis for funding under various Federal programs.

2. State plans. To the extent not presently required by statute or administrative regulation, Federal agencies administering programs requiring by statute or regulation a State plan as a condition of assistance under such programs will require that the Governor, or his delegated agency, be given the opportunity to comment on the relationship of such State plan to comprehensive and other State plans and programs and to those of affected areawide or local jurisdictions. The Governor is urged to involve areawide clearinghouses in the review of State plans, particularly where such plans have specific applicability to or affect areawide or local plans and programs.

a. The Governor will be afforded a period of 45 days in which to make such comments, and any such comments will be transmitted with the plan.

b. A "State plan" under this Part is defined to include any required supporting planning reports or documentation that indicate the programs, projects, and activities for which Federal funds will be utilized. Such reports or documentation will also be submitted for review at the request of the Governor or the agency he has designated to perform review under this Part.

c. Programs requiring State plans are listed in Appendix II of the Catalog of Federal Domestic Assistance.

(No. A-95)

PART IV: COORDINATION OF PLANNING IN MULTIJURISDICTIONAL AREAS

1. Policies and objectives. The purposes of this Part are:

a. To encourage and facilitate State and local initiative and responsibility in developing organizational and procedural arrangements for coordinating comprehensive and functional planning activities.

b. To eliminate overlap, duplication, and competition in areawide planning activities assisted or required under Federal programs and to encourage the most effective use of State and local resources available for planning.

c. To minimize inconsistency among Federal administrative and approval requirements placed on areawide planning activities.

d. To encourage the States to exercise leadership in delineating and establishing a system of planning and development districts or regions in each State, which can provide a consistent geographic base for the planning and coordination of Federal, State, and local development programs.

e. To encourage Federal agencies administering programs assisting or requiring areawide planning to utilize agencies that have been designated to perform areawide comprehensive planning in planning and development districts or regions established pursuant to subparagraph d above (generally, areawide clearinghouses designated pursuant to Part I of Attachment A of this Circular) to carry out or coordinate planning under such programs. In the case of interstate metropolitan areas, agencies designated as metropolitan areawide clearinghouses should be utilized to the extent possible to carry out or coordinate Federally assisted or required areawide planning.

2. Common or consistent planning and development districts or regions.

a. Prior to the designation or redesignation (or approval thereof) of any planning and development district or region under any Federal program, Federal agency procedures will provide a period of 30 days for the

Governor(s) of the State(s) in which the district or region will be located to review the boundaries thereof and comment upon its relationship to planning and development districts or regions established by the State. Where the State has established such planning and development districts, the boundaries of areas designated under Federal programs will conform to them unless there is clear justification for not doing so.

b. Where the State has not established planning and development districts or regions which provide a basis for evaluation of the boundaries of the area proposed for designation, major units of general local government and the appropriate Federal Regional Council in such areas will also be consulted prior to designation of the area to assure consistency with districts established under inter-local agreement and under related Federal programs.

c. The Office of Management and Budget will be notified through the appropriate Federal Regional Council by Federal agencies of any proposed designation and will be informed of such designation when it is made, including such justifications as may be required under subparagraph a above.

3. Common and consistent planning bases and coordination of related activities in multijurisdictional areas. Each agency will develop procedures and requirements for applications for multijurisdictional planning and development assistance under appropriate programs to assure the fullest consistency and coordination with related planning and development being carried on by the areawide comprehensive planning agency or clearinghouse designated under Part I of this Circular in the multijurisdictional area.

Such procedures shall include provision for submission to the funding agency by any applicant for multijurisdictional planning assistance, if the applicant is other than an areawide comprehensive planning agency referred to in paragraph 1e of this Part, of a memorandum of agreement between the applicant and such areawide comprehensive planning agency covering the means by which their planning activities will be coordinated. The agreement will cover but need not be limited to the following matters:

a. Identification of relationships between the planning proposed by the applicant and that of the areawide agency and of similar or related activities that will require coordination;

b. The organizational and procedural arrangements for coordinating such activities, such as: overlapping board membership, procedures for joint reviews of projected activities and policies, information exchange, etc;

c. Cooperative arrangements for sharing planning resources (funds, personnel, facilities, and services);

d. Agreed upon base data, statistics, and projections (social, economic, demographic) on the basis of which planning in the area will proceed.

Where an applicant has been unable to effectuate such an agreement, he will submit a statement indicating the efforts he has made to secure agreement and the issues that have prevented it. In such case, the funding agency, in consultation with the Federal Regional Council and the State clearinghouse designated under Part I, will undertake, within a 30 day period after receipt of the application, resolution of the issues before approving the application, if it is otherwise in good order.

4. Joint funding. Where it will enhance the quality, comprehensive scope, and coordination of planning in multijurisdictional areas, Federal agencies will, to the extent practicable, provide for joint funding of planning activities being carried on therein.

5. Coordination of agency procedures and regulations. With respect to the steps called for in paragraphs 2 and 3 of this Part, departments and agencies will develop for relevant programs appropriate draft procedures and regulations which will be published in the Federal Register pursuant to paragraph 7 of this Circular. Copies of such drafts will be furnished to the Director of the Office of Management and Budget and to the heads of departments and agencies administering related programs. The Office, in consultation with the agencies, will review the draft procedures and regulations to assure the maximum obtainable consistency among them.

PART V: DEFINITIONS

Terms used in this Circular will have the following meanings:

1. Federal agency -- any department, agency, or instrumentality in the executive branch of the Government and any wholly owned Government corporation.

2. State - any of the several States of the United States, the District of Columbia, Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State, but does not include the governments of the political subdivisions of the State.

3. Unit of general local government -- any city, county, town, parish, village, or other general purpose political subdivision of a State.

4. Special purpose unit of local government -- any special district, public purpose corporation, or other strictly limited purpose political subdivision of a State, but shall not include a school district.

5. Federal assistance, Federal financial assistance, Federal assistance programs, or federally assisted programs -- programs that provide assistance through grant or contractual arrangements. They include technical assistance programs, or programs providing assistance in the form of loans, loan guarantees, or insurance. The term does not include any annual payment by the United States to the District of Columbia authorized by article VI of the District of Columbia Revenue Act of 1947 (D.C. Code sec. 47-2501a and 47-2501b).

6. Funding agency. The Federal agency or, in the case of certain formula grant programs, the State agency which is responsible for final approval of applications for assistance.

7. Comprehensive planning, to the extent directly related to area needs or needs of a unit of general local government, including the following:

a. Preparation, as a guide for governmental policies and action, of general plans with respect to:

(1) Pattern and intensity of land use,

(2) Provision of public facilities (including transportation facilities) and other government services.

(3) Effective development and utilization of human and natural resources.

b. Preparation of long range physical and fiscal plans for such action.

c. Programming of capital improvements and other major expenditures, based on a determination of related urgency, together with definitive financing plans for such expenditures in the earlier years of the program.

d. Coordination of all related plans and activities of the State and local governments and agencies concerned.

e. Preparation of regulatory and administrative measures in support of the foregoing.

8. Metropolitan area -- a standard metropolitan statistical area as established by the Office of Management and Budget, subject, however, to such modifications and extensions as the Office of Management and Budget may determine to be appropriate for the purposes of section 204 of the Demonstration Cities and Metropolitan Development Act of 1966, and these Regulations.

9. Areawide -- Comprising, in metropolitan areas, the whole of contiguous urban and urbanizing areas; and in nonmetropolitan areas, contiguous counties or other multijurisdictional areas having common or related social, economic, or physical characteristics indicating a community of developmental interests; or, in either, the area included in a substate district designated pursuant to paragraph 1d, Part IV, Attachment A of this Circular.

10. Planning and development clearinghouse or clearinghouse includes:

a. "State clearinghouse" -- an agency of the State Government designated by the Governor or by State law to carry out the requirements of Part I of Attachment A of this Circular.

b. "Areawide clearinghouse" --

(1) In nonmetropolitan areas a comprehensive planning agency designated by the Governor (or Governors in the case of regions extending into more than one State) or by State law to carry out requirements of this Circular; or

(2) In metropolitan areas an areawide agency that has been recognized by the Office of Management and Budget as an appropriate agency to perform review functions under section 204 of the Demonstration Cities and Metropolitan Development Act of 1966, Title IV of the Intergovernmental Cooperation Act of 1968, and this Circular.

11. Multijurisdictional area -- any geographical area comprising, encompassing, or extending into more than one unit of general local government.

12. Planning and development district or region -- a multijurisdictional area that has been formally designated or recognized as an appropriate area for planning under State law or Federal program requirements.

13. Direct Federal development -- planning and construction of public works, physical facilities, and installations or land and real property development (including the acquisition, use, and disposal of real property) undertaken by or for the use of the Federal Government or any of its agencies; or the leasing of real property for Federal use where the use or intensity of use of such property will be substantially altered.

**ATTACHMENT B
Circular No. A-95
Revised**

SECTION 204 OF THE DEMONSTRATION CITIES AND METROPOLITAN DEVELOPMENT ACT OF 1966 as amended (80 Stat. 1263, 82 Stat. 208)

"Sec. 204. (a) All applications made after June 30, 1967, for Federal loans or grants to assist in carrying out open-space land projects or for planning or construction of hospitals, airports, libraries, water supply and distribution facilities, sewage facilities and waste treatment works, highways, transportation facilities, law enforcement facilities, and water development and land conservation projects within any metropolitan area shall be submitted for review--

"(1) to any areawide agency which is designated to perform metropolitan or regional planning for the area within which the assistance is to be used, and which is, to the greatest practicable extent, composed of or responsible to the elected officials of a unit of areawide government or of the units of general local government within whose jurisdiction such agency is authorized to engage in such planning, and

"(2) if made by a special purpose unit of local government, to the unit or units of general local government with authority to operate in the area within which the project is to be located.

"(b)(1) Except as provided in paragraph (2) of this subsection, each application shall be accompanied (A) by the comments and recommendations with respect to the project involved by the areawide agency and governing bodies of the units of general local government to which the application has been submitted for review, and (B) by a statement by the applicant that such comments and recommendations have been considered prior to formal submission of the application. Such comments shall include information concerning the extent to which the project is consistent with comprehensive planning developed or in the process of development for the metropolitan area or the unit of general local government, as the case may be, and the extent to which such project contributes to the fulfillment of such planning. The comments and recommendations and the statement referred to in this paragraph shall, except in the case referred to in paragraph (2) of this subsection, be reviewed by the agency of the Federal Government to which such application is submitted for the sole purpose of assisting it in determining whether the application is in accordance with the provisions of Federal law which govern the making of the loans or grants.

"(2) An application for a Federal loan or grant need not be accompanied by the comments and recommendations and the statements referred to in paragraph b(1) of this subsection, if the applicant certifies that a plan or description of the project, meeting the requirements of such rules and regulations as may be prescribed under subsection (c), or such application, has lain before an appropriate areawide agency or instrumentality or unit of general local government for a period of sixty days without comments or recommendations thereon being made by such agency or instrumentality.

"(3) The requirements of paragraphs (1) and (2) shall also apply to any amendment of the application which, in light of the purposes of this title, involves a major change in the project covered by the application prior to such amendment.

"(c) The Bureau of the Budget, or such other agency as may be designated by the President, is hereby authorized to prescribe such rules and regulations as are deemed appropriate for the effective administration of this section."

TITLE IV OF THE INTERGOVERNMENTAL COOPERATION ACT OF 1968 (82 Stat. 1103)

"TITLE IV -- COORDINATED INTERGOVERNMENTAL POLICY AND ADMINISTRATION OF DEVELOPMENT ASSISTANCE PROGRAMS"

"DECLARATION OF DEVELOPMENT ASSISTANCE POLICY"

"Sec. 401. (a) The economic and social development of the Nation and the achievement of satisfactory levels of living depend upon the sound and orderly development of all areas, both urban and rural. Moreover, in a time of rapid urbanization, the sound and orderly development of urban communities depends to a large degree upon the social and economic health and the sound development of small communities and rural areas. The President shall, therefore, establish rules and regulations governing the formulation, evaluation, and review of Federal programs and projects having a significant impact on area and community development, including programs providing Federal assistance to the States and localities, to the end that they shall most effectively serve these basic objectives. Such rules and regulations shall provide for full consideration of the concurrent achievement of the following specific objectives and, to the extent authorized by law, reasoned choices shall be made between such objectives when they conflict:

"(1) Appropriate land uses for housing, commercial, industrial, governmental, institutional, and other purposes;

"(2) Wise development and conservation of natural resources, including land, water, minerals, wildlife, and others;

"(3) Balanced transportation systems, including highway, air, water, pedestrian, mass transit, and other modes for the movement of people and goods;

"(4) Adequate outdoor recreation and open space;

"(5) Protection of areas of unique natural beauty, historical and scientific interest;

"(6) Properly planned community facilities, including utilities for the supply of power, water, and communications, for the safe disposal of wastes, and for other purposes; and

best copy available

"(7) Concern for high standards of design.

"(b) All viewpoints -- national, regional, State and local -- shall, to the extent possible, be fully considered and taken into account in planning Federal or federally assisted development programs and projects. State and local government objectives, together with the objectives of regional organizations shall be considered and evaluated within a framework of national public objectives, as expressed in Federal law, and available projections of future national conditions and needs of regions, States, and localities shall be considered in plan formulation, evaluation, and review.

"(c) To the maximum extent possible, consistent with national objectives, all Federal aid for development purposes shall be consistent with and further the objectives of State, regional, and local comprehensive planning. Consideration shall be given to all developmental aspects of our total national community, including but not limited to housing, transportation, economic development, natural and human resources development, community facilities, and the general improvement of living environments.

"(d) Each Federal department and agency administering a development assistance program shall, to the maximum extent practicable, consult with and seek advice from all other significantly affected Federal departments and agencies in an effort to assure fully coordinated programs.

"(e) Insofar as possible, systematic planning required by individual Federal programs (such as highway construction, urban renewal, and open space) shall be coordinated with and, to the extent authorized by law, made part of comprehensive local and areawide development planning."

"FAVORING UNITS OF GENERAL LOCAL GOVERNMENT"

"Sec. 402. Where Federal law provides that both special-purpose units of local government and units of general local government are eligible to receive loans or grants-in-aid, heads of Federal departments and agencies shall, in the absence of substantial reasons to the contrary, make such loans or grants-in-aid to units of general local government rather than to special-purpose units of local government."

(No. A-95)

"RULES AND REGULATIONS"

"Sec. 403. The Bureau of the Budget, or such other agency as may be designated by the President, is hereby authorized to prescribe such rules and regulations as are deemed appropriate for the effective administration of this title."

(No. A-95)

ATTACHMENT C
Circular No. A-95
Revised

SECTION 102 (2) (C) OF THE NATIONAL ENVIRONMENTAL POLICY ACT OF 1969 (83 Stat. 853)

"Sec. 102. The Congress authorizes and directs that, to the fullest extent possible; (1) the policies, regulations, and public laws of the United States shall be interpreted and administered in accordance with the policies set forth in this Act, and (2) all agencies of the Federal Government shall--...

"(C) include in every recommendation or report on proposals for legislation and other major Federal actions significantly affecting the quality of the human environment, a detailed statement by the responsible official on--

"(i) the environmental impact of the proposed action,

"(ii) any adverse environmental effects which cannot be avoided should the proposal be implemented,

"(iii) alternatives to the proposed action,

"(iv) the relationship between local short-term use of man's environment and the maintenance and enhancement of long-term productivity, and

"(v) any irreversible or irretrievable commitments of resources which would be involved in the proposed action should it be implemented.

"Prior to making any detailed statement, the responsible Federal official shall consult with and obtain the comments of any Federal agency which has jurisdiction by law or special expertise with respect to any environmental impact involved. Copies of such statement and the comments and views of the appropriate Federal, State, and local agencies, which are authorized to develop and enforce environmental standards, shall be made available to the President, the Council on Environmental Quality and to the public as provided by section 552 of Title 5, United States Code, and shall accompany the proposal through the existing agency review processes;...."

ATTACHMENT D
Circular No. A-95
Revised

COVERAGE OF PROGRAMS UNDER ATTACHMENT A, Part I

1. Programs listed below are referenced several ways, due to transitional phases in program development, funding status, etc. Generally, citations are to programs as they are listed in the June, 1975 Catalog of Federal Domestic Assistance. For certain new legislation, Catalog citations have not yet been developed. In such cases, references are to Public Law number and section. When no funding is available for a program, it is not generally listed in the Catalog or this Attachment; but if funding becomes available for a program previously covered, it continues to be covered unless specifically exempted by OMB. The Catalog is issued annually and revised periodically during the year. Every effort will be made to keep Appendix I and Attachment D current. Reference should always be made to the one bearing the latest issue date. (However, the update to the 1975 Catalog will not reflect all the changes herein. Therefore, this list should be referenced until issuance of the 1976 Catalog.)

Asterisks indicate certain State formula grant programs requiring State plans which are also covered under Part III. When listed under Part I, reference is to applications for subgrants under the State allocation, not to the State's application for its allocation under the formula grant which is reviewable under Part III.

2. Heads of Federal departments and agencies may, with the concurrence of the Office of Management and Budget, exclude certain categories of projects or activities under listed programs from the requirements of Attachment A, Part I. (Also see Part I, paragraph 8.)

3. Covered programs

Department of Agriculture

10.405 Farm Labor Housing Loans and Grants

10.409	Irrigation, Drainage, and Other Soil and Water Conservation Loans (exception: Loans to grazing associations to develop additional pasturage and loans for purchase of equipment)
10.410	Low to Moderate Income Housing Loans
10.411	Rural Housing Site Loans
10.414	Resource Conservation and Development Loans
10.415	Rural Rental Housing Loans
10.418	Water and Waste Disposal Systems for Rural Communities
10.419	Watershed Protection and Flood Prevention Loans
10.420	Rural Self-Help Housing Technical Assistance
10.422	Business and Industrial Development Loans (Exception: Loans to rural small businesses having no significant impact outside community in which located.)
10.423	Community Facilities Loans
10.424	Industrial Development Grants
10.658	Cooperative Forest Insect and Disease Control
10.901	Resources Conservation and Development (Exception: Small projects costing under $7500 for erosion and sediment control and land stabilization and for rehabilitation and consolidation of existing irrigation systems.)
10.904	Watershed Protection and Flood Prevention

Department of Commerce

11.300	Economic Development-Grants and Loans for Public Works and Development Facilities
11.302	Economic Development-Support for Planning Organizations

11.303 Economic Development-Technical Assistance

11.304 Economic Development-Public Works Impact Projects (Procedural variation)

11.305 Economic Development-State and Local Economic Development Planning

11.306 Economic Development-District Operational Assistance

11.307 Economic Development-Special Economic Development and Adjustment Assistance Program

11.308 Grants to States for Supplemental and Basic Funding of Title I, II, and IV Activities (Basic grants only)

11.405 Anadromous and Great Lakes Fisheries Development

11.407 Commercial Fisheries Research and Development

11.418 Coastal Zone Management Program Development

11.419 Coastal Zone Management Program Administration

11.420 Coastal Zone Management - Estuarine Sanctuaries

Department of Defense

12.101 Beach Erosion Control Projects

12.106 Flood Control Projects

12.107 Navigation Projects

12.108 Snagging and Clearing for Flood Control

Department of Health, Education, and Welfare

13.210* Comprehensive Public Health Services-Formula Grants

13.211* Crippled Children's Services

13.217*	Family Planning Projects
13.224	Health Services Development-Project Grants
13.232*	Maternal and Child Health Services
13.235	Drug Abuse Community Service Programs
13.237	Mental Health-Hospital Improvement Grants
13.240	Mental Health-Community Mental Health Centers
13.246	Migrant Health Grants
13.251	Alcohol-Community Service Programs
13.252	Alcohol Demonstration Programs
13.254	Drug Abuse Demonstration Programs
13.256	Office for Health Maintenance Organization (HMOS)
13.258*	National Health Service Corps
13.259	Mental Health-Children's Services
13.260	Family Planning Services-Training Grants
13.261	Family Health Centers
13.266	Childhood Lead-Based Paint Poisoning Control
13.267	Urban Rat Control
13.268	Disease Control-Project Grants
13.275	Drug Abuse Education Programs
13.284	Emergency Medical Services
13.286	Limitation on Federal Participation for Capital Expenditures
13.340	Health Professions Teaching Facilities-Construction Grants

13.369	Nursing School Construction - Loan Guarantees and Interest Subsidies
13.378	Health Professions Teaching Facilities-Loan Guarantees and Interest Subsidies
13.392	Cancer-Construction
13.400*	Adult Education-Grants to States
13.401	Adult Education-Special Projects
13.408*	Construction of Public Libraries
13.421	Educational Personnel Training Grants-Career Opportunities
13.427	Educationally Deprived Children-Handicapped
13.428*	Educationally Deprived Children-Local Educational Agencies
13.429*	Educationally Deprived Children-Migrants
13.433	Follow Through
13.464*	Library Services-Grants for Public Libraries
13.477	School Assistance in Federally Affected Areas-Construction
13.493*	Vocational Education-Basic Grants to States
13.494*	Vocational Education-Consumer and Homemaking
13.495*	Vocational Education-Cooperative Education
13.499*	Vocational Education-Special Needs
13.501*	Vocational Education - Work Study
13.502*	Vocational Education-Innovation
13.516	Supplementary Educational Centers and Services-Special Progams and Projects

(No. A-95)

13.519*	Supplementary Educational Centers and Services, Guidance, Counseling, and Testing
13.520	Special Programs for Children with Specific Learning Disabilities
13.522	Environmental Education
13.543	Educational Opportunity Centers
13.570*	Libraries and Learning Resources
13.600	Child Development-Head Start
13.612	Native American Programs
13.623	Runaway Youth
13.624*	Rehabilitation Services and Facilities-Basic Support
13.626	Rehabilitation Services and Facilities-Special Projects
13.628	Child Development-Child Abuse and Neglect Prevention and Treatment
13.630*	Developmental Disabilities-Basic Support
13.631	Developmental Disabilities-Special Projects

(No. A-95)

13.633* Special Programs for the Aging - State Agency Activities and Area Planning and Social Services Programs

13.634 Aging Programs Title III, Section 308, Model Projects

13.635* Special Programs for the Aging - Nutrition Program for the Elderly

13.636 Programs for the Aging - Research and Demonstration

13.637* Programs for the Aging - Training

P.L. 93-380: (Section 767) Construction of Academic Facilities

P.L. 93-641: (Section 1516) Planning Grants to Health Systems Agencies; (Section 1601 et seq., Title XVI Public Health Service Act) Assistance for modernization, construction or conversion of medical facilities. These programs will replace Catalog 13.206, 13.220, 13.249, and 13.253.

Department of Housing and Urban Development

14.001 Flood Insurance (Applications for community eligibility)

14.103 Interest Reduction Payments-Rental and Cooperative Housing for Lower Income Families

14.105 Interest Subsidy-Homes for Lower Income Families

14.112 Mortgage Insurance-Construction or Rehabilitiation of Condominium Projects

14.115 Mortgage Insurance-Development of Sales-Type Cooperative Projects

14.116 Mortgage Insurance-Group Practice Facilities

14.117 Mortgage Insurance-Homes

14.118	Mortgage Insurance-Homes for Certified Veterans
14.119	Mortgage Insurance-Homes for Disaster Victims
14.120	Mortgage Insurance-Homes for Low and Moderate Income Families
14.121	Mortgage Insurance-Homes in Outlying Areas
14.122	Mortgage Insurance-Homes in Urban Renewal Areas
14.124	Mortgage Insurance-Investor Sponsored Cooperative Housing
14.125	Mortgage Insurance-Land Development and New Communities
14.126	Mortgage Insurance-Management-Type Cooperative Projects
14.127	Mortgage Insurance-Mobile Home Parks
14.128	Mortgage Insurance-Hospitals
14.129	Mortgage Insurance-Nursing Homes and Related Care Facilities
14.134	Mortgage Insurance-Rental Housing
14.135	Mortgage Insurance-Rental Housing for Moderate Income Families
14.137	Mortgage Insurance-Rental Housing for Low and Moderate Income Families, Market Interest Rate
14.138	Mortgage Insurance-Rental Housing for the Elderly
14.139	Mortgage Insurance-Rental Housing in Urban Renewal Areas
14.141	Nonprofit Housing Sponsor Loans-Planning Projects for Low and Moderate Income Families

14.146	Public Housing-Acquisition (Turnkey and Conventional Production Methods) (New construction only)
14.149	Rent Supplements-Rental Housing for Lower Income Families
14.150	Mortgage Insurance-Experimental Rental Housing
14.156	Lower Income Housing Assistance Program
14.203	Comprehensive Planning Assistance
14.207	New Communities-Loan Guarantees
14.218	Community Development Block Grants-Entitlement Grants
14.219	Community Development Block Grants-Discretionary Grants
14.702	State Disaster Preparedness Grants

Department of the Interior

15.350	Coal Mine Health and Safety Grants
15.400*	Outdoor Recreation-Acquisition, Development and Planning
15.501	Irrigation Distribution System Loans
15.503	Small Reclamation Projects
15.600	Anadromous Fish Conservation
15.605	Fish Restoration
15.611	Wildlife Restoration
15.904	Historic Preservation

Department of Justice

16.500	Law Enforcement Assistance-Comprehensive Planning Grants

16.501	Law Enforcement Assistance-Discretionary Grants
16.502*	Law Enforcement Assistance-Improving and Strengthening Law Enforcement and Criminal Justice
16.515	Criminal Justice Systems Development
16.516	Law Enforcement Assistance - Juvenile Justice and Delinquency Prevention - Allocation to States
16.517	Law Enforcement Assistance Administration - JJPD Special Emphasis Prevention and Treatment

Department of Labor

17.211	Job Corps
17.226	Work Incentives Program (WIN)
17.230	Farm Workers (Procedural variation)
17.232*	Comprehensive Employment and Training Programs

Department of Transportation

20.102	Airport Development Aid Program
20.103	Airport Planning Grant Program
20.205	Highway Research, Planning, and Construction
20.214	Highway Beautification-Control of Outdoor Advertising, Control of Junkyards, Landscaping and Scenic Enhancement
20.500	Urban Mass Transportation Capital Improvement Grants (Planning and construction only)
20.501	Urban Mass Transportation Capital Improvement Loans (Planning and construction only)
20.505	Urban Mass Transportation Technical Studies Grants (Planning and construction only)

20.506	Urban Mass Transportation Demonstration Grants
20.507	Urban Mass Transportation Capital and Operating Assistance Formula Grants

Appalachian Regional Commission

23.003	Appalachian Development Highway System
23.004	Appalachian Health Demonstration
23.005	Appalachian Housing Planning Loan Fund
23.008	Appalachian Local Access Roads
23.010	Appalachian Mine Area Restoration
23.011	Appalachian State Research, Technical Assistance, and Demonstration Projects
23.012	Appalachian Vocational Education Facilities and Operations
23.013	Appalachian Child Development
23.014	Appalachian Housing Site Development and Office State Improvement Grants
23.016	Appalachian Vocational Education and Technical Education Demonstration Grants

(NOTE: Except for 23.011, administration of these grants is not in the Commission but in the appropriate program agency -- e.g., 23.003 is handled by DOT. For 23.002, Appalachian Supplements to Federal Grants-in-aid, which can provide all or any portion of the Federal contribution under certain defined grant-in-aid programs, coverage under Part I is determined by the provisions applicable to the basic grant-in-aid program. For 28.003, 38.003, 48.003, 52.003, and 63.003 - Regional Commission Supplements to Federal Grants-in-aid - the same rule would apply.)

Coastal Plains Regional Commission

28.002 Coastal Plains Technical and Planning Assistance

(See note under Appalachian Regional Commission programs)

Four Corners Regional Commission

38.002 Four Corners Technical and Planning Assistance

(See note under Appalachian Regional Commission programs)

National Science Foundation

47.036 Intergovernmental Science

New England Regional Commission

48.002 New England Technical and Planning Assistance

(See note under Appalachian Regional Commission programs)

Community Services Administration

49.002 Community Action

49.010 Older Persons Opportunities and Services

49.011 Community Economic Development

Ozarks Regional Commission

52.002 Ozarks Technical and Planning Assistance

(See note under Appalachain Regional Commission programs)

Upper Great Lakes Regional Commission

63.002 Upper Great Lakes Technical and Planning Assistance

(See note under Appalachian Regional Commission programs)

Veterans Administration

64.005	Grants to States for Construction of State Nursing Home Care Facilities
64.017	Grants to States for Remodeling of State Home Hospital/Domiciliary Facilities
64.020	Assistance in the Establishment of New State Medical Schools
64.021	Grants to Affiliated Medical Schools-Assistance to Health Manpower Training Institutes
64.114	Veterans Housing-Guaranteed and Insured Loans (GI Home Loans)

Water Resources Council

65.001	Water Resources Planning

Environmental Protection Agency

66.001	Air Pollution Control Program Grants
66.005	Air Pollution Survey and Demonstration Grants
66.027	Solid Waste Planning Grants
66.028	Solid Waste Demonstration Grants
66.418	Construction Grants for Wastewater Treatment Works
66.419	Water Pollution Control-State and Interstate Program Grants

66.426	Water Pollution Control-Areawide Waste Treatment Management Planning Grants
66.432	Grants for State Public Water System Subdivision Programs
66.433	Grants for Underground Injection Control Programs
66.505	Water Pollution Control Demonstration Grants
66.506	Safe Drinking Water Research and Demonstration Grants (Demonstration only)
66.600	Environmental Protection-Consolidated Program Grants
66.602	Environmental Protection - Consolidated Special Purpose Grants.

Action

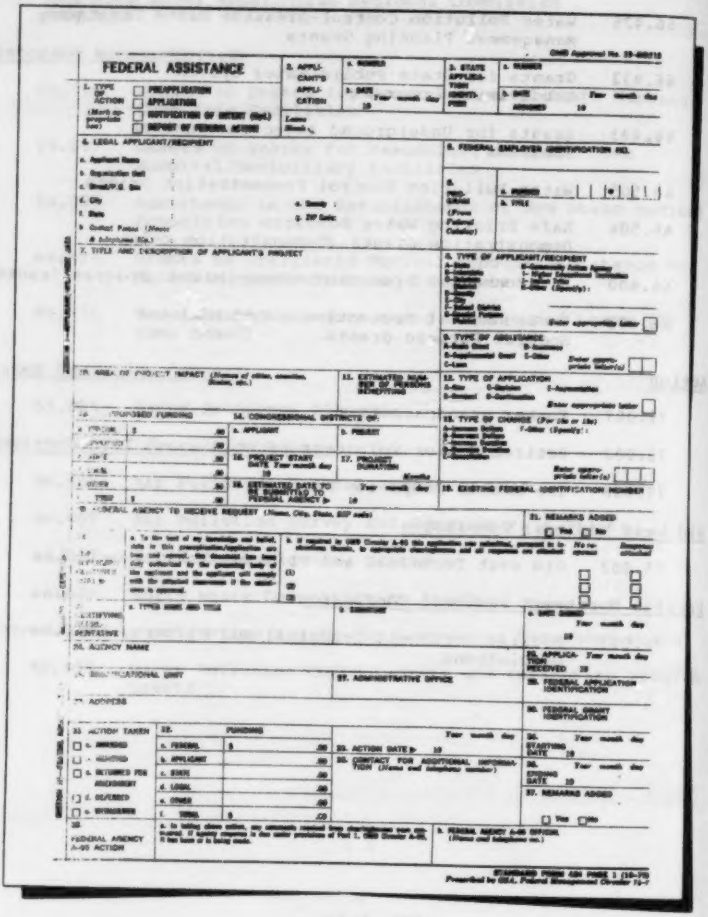
72.001	Foster Grandparents
72.002	Retired Senior Volunteer Program
72.008	The Senior Companion Program

Old West Regional Commission

75.002	Old West Technical and Planning Assistance

Pacific Northwest Regional Commission

76.002	Pacific Northwest Technical and Planning Assistance Regulations



OMB Approval No. 29-R0218

FEDERAL ASSISTANCE

1. TYPE OF ACTION (Mark appropriate box)
☐ PREAPPLICATION
☐ APPLICATION
☐ NOTIFICATION OF INTENT (Opt.)
☐ REPORT OF FEDERAL ACTION

2. APPLICANT'S APPLICATION a. NUMBER b. DATE Year month day 19

3. STATE APPLICATION IDENTIFIER a. NUMBER b. DATE ASSIGNED 19 Year month day

Leave Blank

4. LEGAL APPLICANT/RECIPIENT
a. Applicant Name :
b. Organization Unit :
c. Street/P.O. Box :
d. City : e. County :
f. State : g. ZIP Code:
h. Contact Person (Name & telephone No.) :

5. FEDERAL EMPLOYER IDENTIFICATION NO.

6. PROGRAM (From Federal Catalog) a. NUMBER ☐☐•☐☐☐ b. TITLE

7. TITLE AND DESCRIPTION OF APPLICANT'S PROJECT

8. TYPE OF APPLICANT/RECIPIENT Enter appropriate letter ☐

9. TYPE OF ASSISTANCE Enter appropriate letter(s) ☐☐

10. AREA OF PROJECT IMPACT (Names of cities, counties, States, etc.)

11. ESTIMATED NUMBER OF PERSONS BENEFITING

12. TYPE OF APPLICATION Enter appropriate letter ☐

13. PROPOSED FUNDING
a. FEDERAL $ .00
b. APPLICANT .00
c. STATE .00
d. LOCAL .00
e. OTHER .00
f. TOTAL $ .00

14. CONGRESSIONAL DISTRICTS OF: a. APPLICANT b. PROJECT

15. TYPE OF CHANGE (For 12c or 12e) Enter appropriate letter(s) ☐☐☐

16. PROJECT START DATE Year month day 19

17. PROJECT DURATION Months

18. ESTIMATED DATE TO BE SUBMITTED TO FEDERAL AGENCY ▶ Year month day 19

19. EXISTING FEDERAL IDENTIFICATION NUMBER

20. FEDERAL AGENCY TO RECEIVE REQUEST (Name, City, State, ZIP code)

21. REMARKS ADDED ☐ Yes ☐ No

22. THE APPLICANT CERTIFIES THAT ▶ (1) (2) (3) ☐ ☐ ☐ ☐ ☐ ☐

23. CERTIFYING REPRESENTATIVE a. TYPED NAME AND TITLE b. SIGNATURE c. DATE SIGNED Year month day 19

24. AGENCY NAME

25. APPLICATION RECEIVED Year month day 19

26. ORGANIZATIONAL UNIT

27. ADMINISTRATIVE OFFICE

28. FEDERAL APPLICATION IDENTIFICATION

29. ADDRESS

30. FEDERAL GRANT IDENTIFICATION

31. ACTION TAKEN
☐ a. AWARDED
☐ b. REJECTED
☐ c. RETURNED FOR AMENDMENT
☐ d. DEFERRED
☐ e. WITHDRAWN

32. FUNDING
a. FEDERAL $ .00
b. APPLICANT .00
c. STATE .00
d. LOCAL .00
e. OTHER .00
f. TOTAL $ .00

33. ACTION DATE ▶ Year month day 19

34. STARTING DATE Year month day 19

35. CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number)

36. ENDING DATE Year month day 19

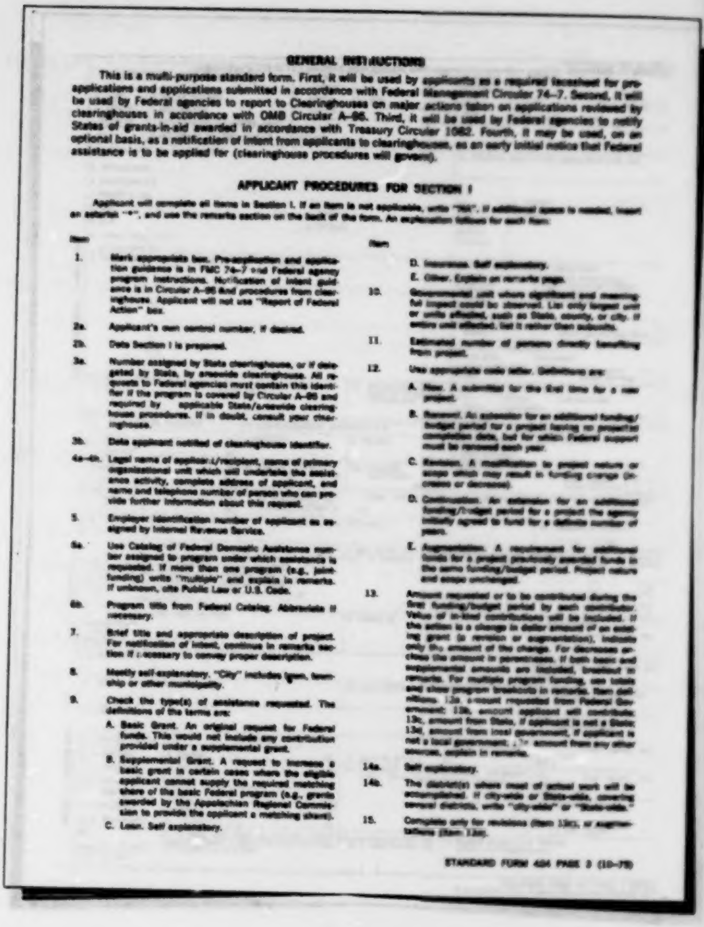
37. REMARKS ADDED ☐ Yes ☐ No

38. FEDERAL AGENCY A-95 ACTION

b. FEDERAL AGENCY A-95 OFFICIAL (Name and telephone no.)

STANDARD FORM 424 PAGE 1 (10-75)

SECTION IV—REMARKS *(Please reference the proper item number from Sections I, II or III, if applicable)*



GENERAL INSTRUCTIONS

This is a multi-purpose standard form. First, it will be used by applicants as a required facesheet for preapplications and applications submitted in accordance with Federal Management Circular 74–7. Second, it will be used by Federal agencies to report to Clearinghouses on major actions taken on applications reviewed by clearinghouses in accordance with OMB Circular A–95. Third, it will be used by Federal agencies to notify States of grants-in-aid awarded in accordance with Treasury Circular 1082. Fourth, it may be used, on an optional basis, as a notification of intent from applicants to clearinghouses, as an early initial notice that Federal assistance is to be applied for (clearinghouse procedures will govern).

APPLICANT PROCEDURES FOR SECTION I

Applicant will complete all items in Section I. If an item is not applicable, write "NA". If additional space is needed, insert an asterisk "*", and use the remarks section on the back of the form. An explanation follows for each item:

Item

1. Mark appropriate box. Pre-application and application guidance is in FMC 74–7 and Federal agency program instructions. Notification of intent guidance is in Circular A–95 and procedures from clearinghouse. Applicant will not use "Report of Federal Action" box.

2a. Applicant's own control number, if desired.

2b. Date Section I is prepared.

3a. Number assigned by State clearinghouse, or if delegated by State, by areawide clearinghouse. All requests to Federal agencies must contain this identifier if the program is covered by Circular A–95 and required by applicable State/areawide clearinghouse procedures. If in doubt, consult your clearinghouse.

3b. Date applicant notified of clearinghouse identifier.

4a–4h. Legal name of applicant/recipient, name of primary organizational unit which will undertake the assistance activity, complete address of applicant, and name and telephone number of person who can provide further information about this request.

5. Employer identification number of applicant as assigned by Internal Revenue Service.

6a. Use Catalog of Federal Domestic Assistance number assigned to program under which assistance is requested. If more than one program (e.g., joint-funding) write "multiple" and explain in remarks. If unknown, cite Public Law or U.S. Code.

6b. Program title from Federal Catalog. Abbreviate if necessary.

7. Brief title and appropriate description of project. For notification of intent, continue in remarks section if necessary to convey proper description.

8. Mostly self-explanatory. "City" includes town, township or other municipality.

9. Check the type(s) of assistance requested. The definitions of the terms are:

   A. Basic Grant. An original request for Federal funds. This would not include any contribution provided under a supplemental grant.

   B. Supplemental Grant. A request to increase a basic grant in certain cases where the eligible applicant cannot supply the required matching share of the basic Federal program (e.g., grants awarded by the Appalachian Regional Commission to provide the applicant a matching share).

   C. Loan. Self explanatory.

   D. Insurance. Self explanatory.

   E. Other. Explain on remarks page.

10. Governmental unit where significant and meaningful impact could be observed. List only largest unit or units affected, such as State, county, or city. If entire unit affected, list it rather than subunits.

11. Estimated number of persons directly benefiting from project.

12. Use appropriate code letter. Definitions are:

   A. New. A submittal for the first time for a new project.

   B. Renewal. An extension for an additional funding/budget period for a project having no projected completion date, but for which Federal support must be renewed each year.

   C. Revision. A modification to project nature or scope which may result in funding change (increase or decrease).

   D. Continuation. An extension for an additional funding/budget period for a project the agency initially agreed to fund for a definite number of years.

   E. Augmentation. A requirement for additional funds for a project previously awarded funds in the same funding/budget period. Project nature and scope unchanged.

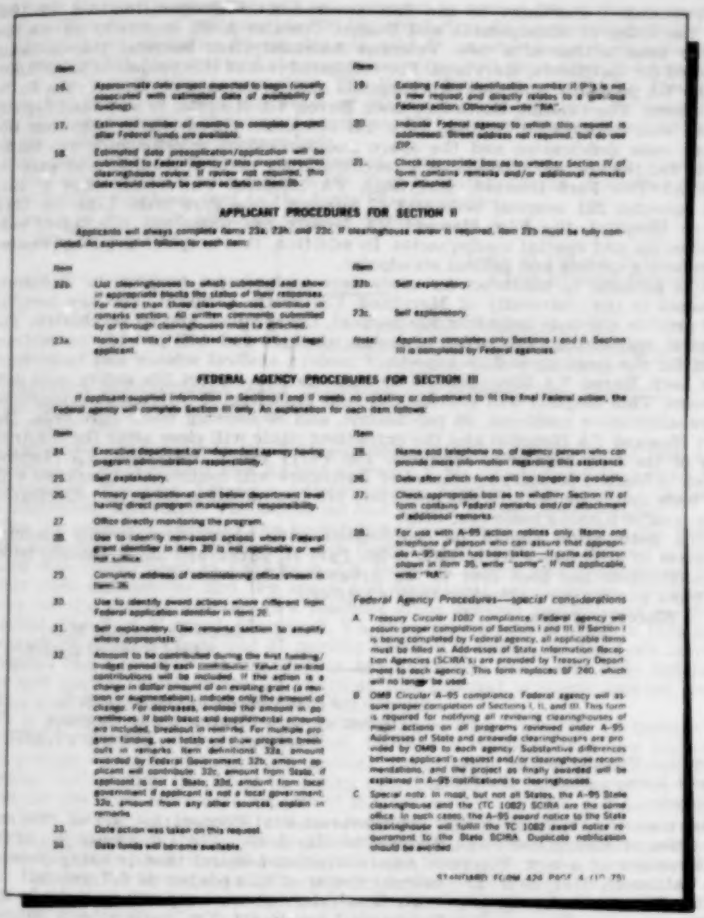
13. Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions will be included. If the action is a change in dollar amount of an existing grant (a revision or augmentation), indicate only the amount of the change. For decreases enclose the amount in parentheses. If both basic and supplemental amounts are included, breakout in remarks. For multiple program funding, use totals and show program breakouts in remarks. Item definitions: 13a, amount requested from Federal Government; 13b, amount applicant will contribute; 13c, amount from State, if applicant is not a State; 13d, amount from local government, if applicant is not a local government; 13e, amount from any other sources, explain in remarks.

14a. Self explanatory.

14b. The district(s) where most of actual work will be accomplished. If city-wide or State-wide, covering several districts, write "city-wide" or "State-wide."

15. Complete only for revisions (item 12c), or augmentations (item 12e).

STANDARD FORM 424 PAGE 3 (10–75)



Item	
16.	Approximate date project expected to begin (usually associated with estimated date of availability of funding).
17.	Estimated number of months to complete project after Federal funds are available.
18.	Estimated date preapplication/application will be submitted to Federal agency if this project requires clearinghouse review. If review not required, this date would usually be same as date in item 2b.

Item	
19.	Existing Federal identification number if this is not a new request and directly relates to a previous Federal action. Otherwise write "NA".
20.	Indicate Federal agency to which this request is addressed. Street address not required, but do use ZIP.
21.	Check appropriate box as to whether Section IV of form contains remarks and/or additional remarks are attached.

APPLICANT PROCEDURES FOR SECTION II

Applicants will always complete items 23a, 23b, and 23c. If clearinghouse review is required, item 22b must be fully completed. An explanation follows for each item:

Item	
22b.	List clearinghouses to which submitted and show in appropriate blocks the status of their responses. For more than three clearinghouses, continue in remarks section. All written comments submitted by or through clearinghouses must be attached.
23a.	Name and title of authorized representative of legal applicant.

Item	
23b.	Self explanatory.
23c.	Self explanatory.
Note:	Applicant completes only Sections I and II. Section III is completed by Federal agencies.

FEDERAL AGENCY PROCEDURES FOR SECTION III

If applicant-supplied information in Sections I and II needs no updating or adjustment to fit the final Federal action, the Federal agency will complete Section III only. An explanation for each item follows:

Item	
24.	Executive department or independent agency having program administration responsibility.
25.	Self explanatory.
26.	Primary organizational unit below department level having direct program management responsibility.
27.	Office directly monitoring the program.
28.	Use to identify non-award actions where Federal grant identifier in item 30 is not applicable or will not suffice.
29.	Complete address of administering office shown in item 26.
30.	Use to identify award actions where different from Federal application identifier in item 28.
31.	Self explanatory. Use remarks section to amplify where appropriate.
32.	Amount to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions will be included. If the action is a change in dollar amount of an existing grant (a revision or augmentation), indicate only the amount of change. For decreases, enclose the amount in parentheses. If both basic and supplemental amounts are included, breakout in remarks. For multiple program funding, use totals and show program breakouts in remarks. Item definitions: 32a, amount awarded by Federal Government; 32b, amount applicant will contribute; 32c, amount from State, if applicant is not a State; 32d, amount from local government if applicant is not a local government; 32e, amount from any other sources, explain in remarks.
33.	Date action was taken on this request.
34.	Date funds will become available.

Item	
35.	Name and telephone no. of agency person who can provide more information regarding this assistance.
36.	Date after which funds will no longer be available.
37.	Check appropriate box as to whether Section IV of form contains Federal remarks and/or attachment of additional remarks.
38.	For use with A-95 action notices only. Name and telephone of person who can assure that appropriate A-95 action has been taken—If same as person shown in item 35, write "same". If not applicable, write "NA".

Federal Agency Procedures—special considerations

A. *Treasury Circular 1082 compliance.* Federal agency will assure proper completion of Sections I and III. If Section I is being completed by Federal agency, all applicable items must be filled in. Addresses of State Information Reception Agencies (SCIRA's) are provided by Treasury Department to each agency. This form replaces SF 240, which will no longer be used.

B. *OMB Circular A-95 compliance.* Federal agency will assure proper completion of Sections I, II, and III. This form is required for notifying all reviewing clearinghouses of major actions on all programs reviewed under A-95. Addresses of State and areawide clearinghouses are provided by OMB to each agency. Substantive differences between applicant's request and/or clearinghouse recommendations, and the project as finally awarded will be explained in A-95 notifications to clearinghouses.

C. *Special note.* In most, but not all States, the A-95 State clearinghouse and the (TC 1082) SCIRA are the same office. In such cases, the A-95 award notice to the State clearinghouse will fulfill the TC 1082 award notice requirement to the State SCIRA. Duplicate notification should be avoided.

STANDARD FORM 424 PAGE 4 (10-75)

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 7, 1977.

DEPARTMENT OF STATE PLANNING,
Baltimore, Md.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans Administration hospital that is being planned for Baltimore, Maryland. The estimated cost of this project is $87,000,000.

The VA presently operates two hospitals and an outpatient clinic in the Baltimore area. The existing Baltimore Loch Raven VA Hospital is a 291-bed facility which was constructed in 1952 as a TB Hospital. There exists numerous life safety code deficiencies and the space and functional relationships are inadequate for the current mission as a teaching acute general medical and surgical hospital. The Fort Howard, Maryland, VA Hospital was constructed in 1942 and operates 231 hospital beds and 47 nursing home care beds. Like the Loch Raven Hospital, the Fort Howard VA facility has numerous life safety code deficiencies and spatial inadequacies. In addition, this hospital is poorly located from both a staffing and patient standpoint.

It is planned to construct an acute care replacement hospital in Baltimore adjacent to the University of Maryland, University Hospital. The new hospital will provide 400 beds including 220 medical, 120 surgical, and 60 psychiatric. The hospital will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology. The Loch Raven VA Hospital will be renovated to correct life safety code deficiencies. This hospital will provide 250 beds including 60 intermediate medicine, 80 rehabilitative medicine, 30 psychiatric, and 80 nursing home care beds. The Fort Howard VA Hospital and the outpatient clinic will close after the construction of the new facility is complete. The Perry Point, Maryland, VA Hospital which is located 60 miles northeast of Baltimore will continue in operation with 950 beds including 80 internal medicine, 470 intermediate medicine, 320 psychiatric, and 80 nursing home care beds.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similiar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 7, 1977.

REGIONAL PLANNING COUNCIL,
Mount Vernon Medical Building,
Baltimore, Md.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95; this is to advise you of the construction of a new Veterans Administration hospital that is being planned for Baltimore, Maryland. The estimated cost of this project is $87,000,000.

The VA presently operates two hospitals and an outpatient clinic in the Baltimore area. The existing Baltimore Loch Raven VA Hospital is a 291-bed facility which was constructed in 1952 as a TB Hospital. There exists numerous life safety code deficiencies and the space and functional relationships are inadequate for the current mission as a teaching acute general medical and surgical hospital. The Fort Howard, Maryland, VA Hospital was constructed in 1942 and operates 231 hospital beds and 47 nursing home care beds. Like the Loch Raven Hospital, the Fort Howard VA facility has numerous life safety code deficiencies and spatial inadequacies. In addition, this hospital is poorly located from both a staffing and patient accessibility standpoint.

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It is planned to construct an acute care replacement hospital in Baltimore adjacent to the University of Maryland, University Hospital. The new hospital will provide 400 beds including 220 medical, 120 surgical, and 60 psychiatric. The hospital will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology. The Loch Raven VA Hospital will be renovated to correct life safety code deficiencies. This hospital will provide 250 beds including 60 intermediate medicine, 80 rehabilitative medicine, 30 psychiatric, and 80 nursing home care beds. The Fort Howard VA Hospital and the outpatient clinic will close after the construction of the new facility is complete. The Perry Point, Maryland, VA Hospital which is located 60 miles northeast of Baltimore will continue in operation with 950 beds including 80 internal medicine, 470 intermediate medicine, 320 psychiatric, and 80 nursing home care beds.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 7, 1977.

WILMINGTON METROPOLITAN AREA PLANNING AND COORDINATING COUNCIL,
Cross Roads Shopping Center,
New Castle, Del.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of the construction of a new Veterans Administration hospital that is being planned for Baltimore, Maryland. The estimated cost of this project is $87,000,000.

The VA presently operates two hospitals and an outpatient clinic in the Baltimore area. The existing Baltimore Loch Raven VA Hospital is a 291-bed facility which was constructed in 1952 as a TB Hospital. There exists numerous life safety code deficiencies and the space and functional relationships are inadequate for the current mission as a teaching acute general medical and surgical hospital. The Fort Howard, Maryland, VA Hospital was constructed in 1942 and operates 231 hospital beds and 47 nursing home care beds. Like the Loch Raven Hospital, the Fort Howard VA facility has numerous life safety code deficiencies and spatial inadequacies. In addition, this hospital is poorly located from both a staffing and patient accessibility standpoint.

It is planned to construct an acute care replacement hospital in Baltimore adjacent to the University of Maryland, University Hospital. The new hospital will provide 400 beds including 220 medical, 120 surgical, and 60 psychiatric. The hospital will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology. The Loch Raven VA Hospital will be renovated to correct life safety code deficiencies. This hospital will provide 250 beds including 60 intermediate medicine, 80 rehabilitative medicine, 30 psychiatric, and 80 nursing home care beds. The Fort Howard VA Hospital and the outpatient clinic will close after the construction of the new facility is complete. The Perry Point, Maryland, VA Hospital which is located 60 miles northeast of Baltimore will continue in operation with 950 beds including 80 internal medicine, 470 intermediate medicine, 320 psychiatric, and 80 nursing home care beds.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., June 4, 1976.

TAMPA BAY REGIONAL PLANNING COUNCIL,
St. Petersburg, Fla.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans Administration Hospital that is being planned at the Bay Pines, Florida, VA Center. The estimated cost of this project is $110,000,000.

The VA Center at Bay Pines was constructed during the 1930's and 1940's and is operating 673 hospital beds, 120 nursing home care beds, and a 322 bed domiciliary. The nursing home care unit is in a new structure which was activated in 1973. The existing buildings at this facility, excluding the nursing home, are old and antiquated structures which do not meet space or functional requirements for medical facilities or safety and construction code requirements. Patient ward areas and clinical support areas are grossly overcrowded.

It is our plan to construct a replacement hospital at the existing Bay Pines site. The new hospital will house 520 medical and surgical beds, an additional 120 bed nursing home care unit, and a 200 bed domiciliary to replace the existing domiciliary beds. In addition, the existing 120 bed nursing home care unit will be renovated. The renovated buildings will house 190 psychiatric beds, administration, and the ambulatory care functions. This new facility will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with area health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., June 4, 1976.

BUREAU OF INTERGOVERNMENTAL RELATIONS,
Division of State Planning, Department of Administration,
Tallahassee, Fla.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans Administration Hospital that is being planned at the Bay Pines, Florida, VA Center. The estimated cost of this project is $110,000,000.

The VA Center at Bay Pines was constructed during the 1930's and 1940's and is operating 673 hospital beds, 120 nursing home care beds, and a 322 bed domiciliary. The nursing home care unit is in a new structure which was activated in 1973. The existing buildings at this facility, excluding the nursing home, are old and antiquated structures which do not meet space or functional requirements for medical facilities or safety and construction code requirements. Patient ward areas and clinical support areas are grossly overcrowded.

It is our plan to construct a replacement hospital at the existing Bay Pines site. The new hospital will house 520 medical and surgical beds, an additional 120 bed nursing home care unit, and a 200 bed domiciliary to replace the existing domiciliary beds. In addition, the existing 120 bed nursing home care unit will remain in its present facility and three other buildings will be renovated. The renovated buildings will house 190 psychiatric beds, administration, and the ambulatory care functions. This new facility will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with area health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 8, 1977.

DELAWARE VALLEY REGIONAL PLANNING COMMISSION,
Penn Towers Building, Philadelphia, Pa.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans Administration hospital that is being planned in Camden, New Jersey. The estimated cost of this project is $75,300,000.

There are approximately 700,000 veterans residing in the Philadelphia/South New Jersey area. These veterans are now predominantly served by the 490-bed VA hospital in Philadelphia, Pennsylvania. Additional beds and outpatients facilities are required to meet the health care needs of these veterans. The availability of VA resources in this area is far below the rest of the nation. The national average of VA beds per 1,000 veteran population is 3.2 beds. The present ration in the Philadelphia/Southern New Jersey area is 0.7 beds. Our demographic study of the area projects a 1985 need of 360 additional VA hospital beds.

The new hospital, which will be located adjacent to the Cooper Hospital in Camden, will contain 360 hospital beds including 300 medical, surgical, and neurological and 60 psychiatric beds. In addition, 120 nursing home care beds will be provided to meet the growing need for this type of care for our aging veterans. These new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 8, 1977.

BUREAU OF STATE AND REGIONAL PLANNING,
Department of Community Affairs,
Trenton, N.J.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans Administration hospital that is being planned in Camden, New Jersey. The estimated cost of this project is $75,300,000.

There are approximately 700,000 veterans residing in the Philadelphia/South New Jersey area. These veterans are now predominantly served by the 490-bed VA hospital in Philadelphia, Pennsylvania. Additional beds and outpatient facilities are required to meet the health care needs of these veterans. The availability of VA resources in this area is far below the rest of the nation. The national average of VA beds per 1,000 veteran population is 3.2 beds. The present ration in the Philadelphia/Southern New Jersey area is 0.7 beds. Our demographic study of the area projects a 1985 need of 360 additional VA hospital beds.

The new hospital, which will be located adjacent to the Cooper Hospital in Camden, will contain 360 hospital beds including 300 medical, surgical, and neurological and 60 psychiatric beds. In addition, 120 nursing home care beds will be provided to meet the growing need for this type of care for our aging veterans. These new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

FEBRUARY 1, 1977.

DEPARTMENT OF LOCAL SERVICES,
State Planning and Development Clearinghouse,
First National Building,
Little Rock, Ark.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 an the Office of Management and Budget Circular A-95, this is to advise you o the construction of a new Veterans Administration hospital that is bein planned in Little Rock, Arkansas. The estimated cost of this project i $115,000,000.

The present Little Rock VA hospital is composed of two separate division The Little Rock Division, which was constructed in 1950, provides acute medica and surgical care. The hospital does not have adequate facilities for the curren and projected mission and workload. In addition, extensive improvements ar required to meet current construction and safety codes. Parking facilities ar critically deficient. The modernization and expansion of this facility to provi necessary space and functional arrangement is economically not feasible. Th North Little Rock Division was constructed in 1895 and provides psychiatric intermediate, and nursing home care. Improvements have been made throug the years; however, all existing buildings require further improvements an alterations to meet current space and functional requirements and correct lif safety code deficiencies. The two divisions collectively operate a total of 1,0 beds.

It is planned to construct a new 460-bed acute care hospital at the University of Arkansas Medical Center consisting of 400 medical and surgical beds an 60 psychiatric beds. This new facility will employ the latest in design concept and will establish an environment for the most up-to-date aspects of moder medical science and technology. In addition, selected facilities at the Nort Little Rock Division will be modernized to provide 70 neurological, 200 inter mediate, and 930 psychiatric beds, and the retention of 300 existing nursing hom care beds for a total of 1,080 beds at this division.

This notification should be coordinated with appropriate health plannin agencies in accordance with OMB A-95, Part II, paragraph 2a. A similar lette of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

FEBRUARY 1, 1977.

METROPLAN,
Continental Building,
Little Rock, Ark.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1958 an the Office of Management and Budget Circular A-95, this is to advise you o the construction of a new Veterans Administration hospital that is being planne in Little Rock, Arkansas. The estimated cost of this project is $115,000,000.

The present Little Rock VA hospital is composed of two separate division The Little Rock Division, which was constructed in 1950, provides acute medica and surgical care. The hospital does not have adequate facilities for the curren and projected mission and workload. In addition, extensive improvements ar required to meet current construction and safety codes. Parking facilities ar critically deficient. The modernization and expansion of this facility to provide necessary space and functional arrangement is economically not feasible The North Little Rock Division was constructed in 1896 and provides psychiatric, intermediate, and nursing home care. Improvements have been mad through the years; however, all existing buildings require further improvement and alterations to meet current space and functional requirements and correc life safety code deficiencies. The two divisions collectively operate a total o 1,857 beds.

It is planned to construct a new 480-bed acute care hospital at the University of Arkansas Medical Center consisting of 400 medical and surgical beds and psychiatric beds. This new facility will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology. In addition, selected facilities at the North Little Roc

Division will be modernized to provide 70 neurological, 200 intermediate, and 930 psychiatric beds, and the retention of 200 existing nursing home care beds for a total of 1,080 beds at this division.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

FEBRUARY 1, 1977.

REGION IX PLANNING AND DEVELOPMENT COUNCIL,
Martinsburg, W. Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a new Veterans Administration Hospital that is being planned at the Martinsburg, West Virginia, VA Center. The estimated cost of this project is $76,000,000.

The existing VA hospital in Martinsburg was constructed by the United States Army in 1943 for use as a temporary hospital. The facilities were transferred to the VA in 1946. The hospital presently operates 675 hospital beds and 550 domiciliary beds. The Center consists of small one- and two-story buildings connected by a system of corridors. The total health care delivery system in this Center is restricted and impeded by the overwhelming distances to be traversed by patients, personnel, and supplies. The deterioration of the facility demands excessive maintenance. Numerous fire and safety deficiencies have resulted from the age and design of the facility.

The new facility, which will be constructed on the existing site, will contain a total of 1,040 beds, of which 240 medical, 70 surgical, and 60 psychiatric shall be in a newly constructed 370-bed hospital. In addition, a new 120-bed nursing home care unit and the replacement by new construction of 200 of the existing 550 domiciliary beds will be provided. The new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

FEBRUARY 1, 1977.

GRANT INFORMATION DEPARTMENT,
Office of Federal State Relations,
State Capitol Building,
Charleston, W. Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a new Veterans Administration Hospital that is being planned at the Martinsburg, West Virginia, VA Center. The estimated cost of this project is $76,000,000.

The existing VA hospital in Martinsburg was constructed by the United States Army in 1943 for use as a temporary hospital. The facilities were transferred to the VA in 1946. The hospital presently operates 675 hospital beds and 550 domiciliary beds. The Center consists of small one- and two-story buildings connected by a system of corridors. The total health care delivery system in this Center is restricted and impeded by the overwhelming distances to be traversed by patients, personnel, and supplies. The deterioration of the facility demands excessive maintenance. Numerous fire and safety deficiencies have resulted from the age and design of the facility.

The new facility, which will be constructed on the existing site, will contain a total of 1,040 beds, of which 240 medical, 70 surgical, and 60 psychiatric shall be in a newly constructed 370-bed hospital. In addition, a new 120-bed nursing home care unit and the replacement by new construction of 200 of the existing 550 domiciliary beds will be provided. The new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 1, 1977.

COLUMBIA REGION ASSOCIATION OF GOVERNMENTS,
University Center Building Portland, Oreg.

GENTLEMAN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of the construction of a new Veterans Administration Hospital that is being planned in Portland, Oregon. The estimated cost of this project is $154,600,000.

The VA presently operates two hospitals in the Portland metropolitan area. The Portland, Oregon, Hospital is located in the Marquam Hill area of the city near the University of Oregon Health Sciences Center. The original buildings of the hospital were constructed in 1928. A support building was added in 1932 and a tuberculosis building was built in 1949. Several quonset huts were added from the late 1940's to mid 1950's. The facilities are grossly inadequate in space and in functional inter-relationships. Severe overcrowding exists in the clinical support areas and on the patient wards. There are numerous life safety code deficiencies. This hospital currently operates 527 hospital beds.

The VA Hospital in Vancouver, Washington, is a cantonment type facility which was constructed in 1941 as an Army Hospital with a life expectancy of 10 years. The facility was acquired by the VA in 1946 for temporary use until such time as permanent hospital facilities were provided in the area. The Vancouver Hospital consists of over 75 wood frame buildings widely dispersed on the site and connected by a corridor system of over one mile in length. Like the Portland Hospital, Vancouver is an antiquated facility lacking in space and having poor functional layout and numerous life safety deficiencies. The Vancouver Hospital presently operates 376 hospital beds.

The new hospital, which will be located on the site of the existing Portland VA Hospital, will contain 770 hospital beds including 680 medical and surgical beds and 90 psychiatric beds. In addition, a 120-bed nursing home care unit will be provided. The new hospital will replace the two existing VA hospitals. These new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology. The existing VA outpatient clinic in downtown Portland will continue to operate in its present location.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention in this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Direcor.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 1, 1977.

FEDERAL AID COORDINATOR,
Intergovernmental Relations Division, Executive Department, Salem, Oreg.

DEAR SIR: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of the construction of a new Veterans' Administration Hospital that is being planned in Portland, Oregon. The estimated cost of this project is $154,600,000.

The VA presently operates two hospitals in the Portland metropolitan area. The Portland, Oregon, Hospital is located in the Marquam Hill area of the city near the University of Oregon Health Sciences Center. The original buildings of the hospital were constructed in 1928. A support building was added in 1932 and a tuberculosis building was built in 1949. Several quonset huts were added from the late 1940's to mid 1950's. The facilities are grossly inadequate in space and in functional inter-relationships. Severe overcrowding exists in the clinical support areas and on the patient wards. There are numerous life safety code deficiencies. This hospital currently operates 527 hospital beds.

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This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention in this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 1, 1977.

OFFICE OF THE GOVERNOR,
Office of Program Planning and Fiscal Management,
Olympia, Wash.

DEAR SIR: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of the construction of a new Veterans Administration Hospital that is being planned in Portland, Oregon. The estimated cost of this project is $154,600,000.

The VA presently operates two hospitals in the Portland metropolitan area. The Portland, Oregon, Hospital is located in the Marquam Hill area of the city near the University of Oregon Health Sciences Center. The original buildings of the hospital were constructed in 1928. A support building was added in 1932 and a tuberculosis building was built in 1949. Several quonset huts were added from the late 1940's to mid 1950's. The facilities are grossly inadequate in space and in functional inter-relationships. Severe overcrowding exists in the clinical support areas and on the patient wards. There are numerous life safety code deficiencies. This hospital currently operates 527 hospital beds.

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The new hospital, which will be located on the site of the existing Portland VA Hospital, will contain 770 hospital beds including 680 medical and surgical beds and 90 psychiatric beds. In addition, a 120-bed nursing home care unit will be provided. The new hospital will replace the two existing VA hospitals. These new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology. The existing VA outpatient clinic in downtown Portland will continue to operate in its present location.

This notification should be coordinated with appropriate health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention in this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., February 1, 1977.

REGIONAL PLANNING COUNCIL OF CLARK COUNTY,
Vancouver, Wash.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans' Administration Hospital that is being planned in Portland, Oregon. The estimated cost of this project is $154,600,000.

The VA presently operates two hospitals in the Portland metropolitan area. The Portland, Oregon, Hospital is located in the Marquam Hill area of the city near the University of Oregon Health Sciences Center. The original buildings of the hospital were constructed in 1928. A support building was added in 1932 and a tuberculosis building was built in 1949. Several quonset huts were added from the late 1940's to mid 1950's. The facilities are grossly inadequate in space and in functional inter-relationships. Severe overcrowding exists in the clinical support areas and on the patient wards. There are numerous life safety code deficiencies. This hospital currently operates 527 hospital beds.

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The new hospital, which will be located on the site of the existing Portland VA Hospital, will contain 770 hospital beds including 680 medical and surgical beds and 90 psychiatric beds. In addition, a 120-bed nursing home care unit will be provided. The new hospital will replace the two existing VA hospitals. These new facilities will employ the latest in design concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology. The existing VA outpatient clinic in downtown Portland will continue to operate in its present location.

This notification should be coordinated with appropriate health planning agencies in accordance with A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention in this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., June 4, 1976.

RICHMOND REGIONAL PLANNING DISTRICT COMMISSION,
Richmond, Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a new hospital being planned as a replacement for the existing Veterans Administration Hospital at Richmond, Virginia. The estimated cost of this replacement hospital is $116,000,000.

The existing VA Hospital in Richmond is a 865 bed facility which was activated by the Army in 1944 and acquired by the VA in 1946. The hospital presently operates in approximately 80 buildings including 75 one-story and two-story of the cantonment type interconnected by a 14 mile corridor system.

The new hospital, which will be constructed on the 132 acre site of the existing hospital, will contain 700 hospital beds and a 120 bed nursing home care unit. The hospital will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., June 4, 1976.

DIVISION OF STATE PLANNING AND COMMUNITY AFFAIRS,
James Madison Building,
Richmond, Va.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A–95, this is to advise you of a new hospital being planned as a replacement for the existing Veterans Administration Hospital at Richmond, Virginia. The estimated cost of this replacement hospital is $116,000,000.

The existing VA Hospital in Richmond is a 865 bed facility which was activated by the Army in 1944 and acquired by the VA in 1946. The hospital presently operates in approximately 80 buildings including 75 one-story and two-story of the cantonment type interconnected by a 14 mile corridor system.

The new hospital, which will be constructed on the 132 acre site of the existing hospital, will contain 700 hospital beds and a 120 bed nursing home care unit. The hospital will employ the latest in design concepts and will provide an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with OMB A–95, Part II, paragraph 2a. A similar letter of notification has been sent to the Areawide Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

FEBRUARY 1, 1977.

OFFICE OF THE GOVERNOR,
Office of Program Planning and Fiscal Management,
Olympia, Wash.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1988 and the Office of Management and Budget Circular A–95, this is to advise you of the construction of a new Veterans Administration hospital that is being planned in Seattle, Washington. The estimated cost of this project is $90,000,000.

The VA hospital in Seattle is located on a 34 acre tract of land, 3½ miles south of the city's business district. The main hospital and 5 support buildings were completed in 1951. Six additional small buildings and 2 trailers have been added and the most recent construction is a pre-engineered metal building completed in 1972. The hospital has major inadequacies including space shortages and poor functional relationships, substandard utilities, and seismic and life safety code deficiencies. The hospital is presently a 346 bed facility.

The new hospital, which will be located on the present site, will consist of a major addition to the existing main hospital building. The addition will contain 515 beds including 320 medical and surgical, 90 psychiatric, 45 spinal cord injury, and 60 nursing home care. The new construction will also house inpatient

diagnostic and support services and a parking structure. In addition, the existing hospital will be renovated for ambulatory care, administration, off-ward education, warehouse functions, and other non-direct patient care functions. These new facilities will employ the latest concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

FEBRUARY 1, 1977.

PUGET SOUND GOVERNMENTAL CONFERENCE,
Seattle, Wash.

GENTLEMEN: Pursuant to the Intergovernmental Cooperation Act of 1968 and the Office of Management and Budget Circular A-95, this is to advise you of the construction of a new Veterans Administration hospital that is being planned in Seattle, Washington. The estimated cost of this project is $90,000,000.

The VA hospital in Seattle is located on a 34 acre tract of land, 3½ miles south of the city's business district. The main hospital and 5 support buildings were completed in 1951. Six additional small buildings and 2 trailers have been added and the most recent construction is a pre-engineered metal building completed in 1972. The hospital has major inadequacies including space shortages and poor functional relationships, substandard utilities, and seismic and life safety code deficiencies. The hospital is presently a 346 bed facility.

The new hospital, which will be located on the present site, will consist of a major addition to the existing main hospital building. The addition will contain 515 beds including 320 medical and surgical, 90 psychiatric, 45 spinal cord injury, and 60 nursing home care. The new construction will also house inpatient diagnostic and support services and a parking structure. In addition, the existing hospital will be renovated for ambulatory care, administration, off-ward education, warehouse functions, and other non-direct patient care functions. These new facilities will employ the latest concepts and will establish an environment for the most up-to-date aspects of modern medical science and technology.

This notification should be coordinated with appropriate health planning agencies in accordance with A-95, Part II, paragraph 2a. A similar letter of notification has been sent to the State Clearinghouse.

Thank you for your attention to this matter.

Sincerely yours,

JOHN D. CHASE, M.D.,
Chief Medical Director.

Mr. STEINBERG. With respect to your desire to share as much possible information with the community, I would like to know whether or not this document, the overview and the draft master plan have been shared with all of the community organizations that are here today represented?

Dr. BAGANZ. The master plan document has not been shared. We just received it, the advance draft copy, on Monday. The overview document has been shared with the congressional delegation and with the HSA.

Mr. STEINBERG. Is there any reason why it cannot be shared with the other organizations?

Dr. BAGANZ. No. No reason at all.

Mr. STEINBERG. Is there any reason why the draft master plan cannot be shared with them?

Dr. BAGANZ. It should not be shared until after April 15 when it has been finalized. It is in draft form yet. It would be wiser, I think, to wait until the consultant delivers the final product.

Mr. Steinberg. Has that been shared with the HSA?

Dr. Baganz. Not to my knowledge.

Mr. Mitchell. I just received a copy today.

Dr. Baganz. It's informal, in-house at the moment. We have no problem sharing it, but it's still a draft report.

Mr. Steinberg. Their process is moving forward at such a pace that it seems to me they may well need it.

Dr. Baganz. With an understanding, it has to have a caveat that it's not final we have no problems.

Mr. Steinberg. Could we ask you, please, as soon as the master plan is made final, or on April 15, whichever comes first, in order to expedite that process, to share with the organizations that are represented here today—including the veterans organizations as well as the community organizations—copies of that document and to share immediately with those other organizations the overview document that you have presented to us and to the HSA?

Dr. Baganz. Yes.

[Subsequently, the Veterans' Administration furnished the following information:]

Attached is a copy of "Master Plan Concepts" for VAMC Minneapolis dated June 11, 1979, which represents the options offered. Please note that the cost estimates for each option displayed in this report do not include full escalation costs, design, contingency or service costs.

MASTER PLAN CONCEPTS

VAMC MINNEAPOLIS, MINNESOTA

PROJECT NUMBER 618-063
CONTRACT NUMBER V101C-521

June 11, 1979

ELLERBE ASSOCIATES, INC.
ARCHITECTS/ENGINEERS/PLANNERS
Bloomington, Minnesota 55420
Telephone 612/853-2000

PROBLEM STATEMENT

The problem examined in this study is to develop a plan, based on the projected 1985 space requirements as determined by the Health Care Facilities Service of the VA Central Office (VACO) for the development of the VA Medical Center at Minneapolis, Minnesota. It is an examination of the space requirements and location relationships of all services of the VAMC at one time and then an examination of various ways in which the provision of those space requirements might be achieved. It is a long range master plan in that the plan provides for both the eventual replacement of all existing facilities and the expansion of facilities constructed to meet space needs which may develop after 1985. No specific space program is provided for those projected requirements. Rather, directions of expansion are to be available for all services to develop as needed.

The master plan to be developed is intended for two purposes:

1. To identify any and all projects which should be completed in an immediate or phased development project; and
2. To guide even further development as needs or requirements are determined or funded.

The charge to Ellerbe follows two earlier phases of the planning contract--(a) a Technical Evaluation of Existing Facilities in which the architectural features and conditions of most VAMC buildings was documented and (b) a Programming Assistance phase in which the Ellerbe staff assisted in identifying space requirements thereby gaining an early insight into essential requirements and relationships within the VAMC station. During this Programming Assistance phase, the Ellerbe staff had the opportunity to interview the staff of the various services, both at the station and in the Department of Medicine and Surgery in the VACO.

The charge to Ellerbe in this phase, and documented in this report, is to prepare concepts for three alternative types of development. These three alternatives are intended to be developed to a sufficient extent to permit the VA to make a selection of one of the three as the concept which is to be further developed as the master plan development concept. The methodology employed in the study included a close working relationship with the Health Care Facilities Service and through the HCFS with both the DMS staff and the VAMC station staff. The Ellerbe staff performed this effort on site in facilities made available in the Engineering Building. Close relationships with the HCFS staff were maintained through periodic visits by that staff to the site and more frequently by telephone discussion of pertinent points. Location on site permitted the Ellerbe staff to have informal contact with the station staff and in some cases to act in a liaison role between the station staff and the HCFS staff.

The three alternatives to be considered were determined by the VA and are identified in the Scope of Work as:

A. Complete replacement facility on this site or another site.

B. Phased replacement retaining buildings 43 and 49 with first priority given to the inpatient bed areas.

C. Phased replacement retaining buildings 43 and 49 with first priority given to the Ambulatory Care Facility.

During the course of concept development and during an interim review with VACO and station staff, the above alternatives were slightly modified to permit consideration of replacing all existing research space, including building 49 and space in and near building 31. Prior to this modification, research space was not considered in the concept development.

As will be noted in this study report, consideration of these three alternatives is not clear and distinct. Three development concepts are presented but each concept may satisfy two or all three alternatives. While each concept is not fully developed for each satisfied alternative, the necessary changes to accomplish this are discussed in each concept presentation.

The Ellerbe effort proceeded in generally the following chronology:

1. The space program was summarized in logical groupings and subservice or departmental areas. Appropriate transfer of space (i.e., LLTS, staff offices, educational space, etc.) were made, bed unit configurations were changed in accord with developing schemes, the space program was modified as ongoing HCFS efforts identified space program changes.
2. Information gained from interviews with the staff of most of the station services and with their counterparts in the Department of Medicine and Surgery in VACO was used to suggest appropriate interdepartmental relationships and program reallocations.
3. Site considerations--access, orientation, prevailing weather, etc.--were analyzed and intuitive sketches were prepared demonstrating potential development and land use. Appropriate contacts with governmental agencies were made along with the VACO staff.
4. Structural features of existing buildings to remain in use (buildings 43 and 49) were reviewed in relation to desired features of current buildings.

5. Various concepts and relationships were considered as to functional relationships, code restrictions, operating systems, phasing development, site use, long term or ultimate development, etc.

6. Selected concepts were then developed as presented in this study report. Cost comparisons and the report narrative were prepared.

7. An interim review was conducted with HCFS and other VACO and station staff midway through concept development. This review presented study findings for discussion and gave direction to further development.

The resulting report, while presented as an Ellerbe study project, is in fact a joint study with the HCFS, DM&S and other VACO staff. The generous cooperation of the VA staff, both CO and station, is sincerely appreciated.

VAMC - Minneapolis

There are several very significant characteristics of the VAMC - Minneapolis station which have a major impact on concept development and which should be considered as a background to the development of the master plan concept.

Without question the major such characteristic is the highly specialized, teaching and research aspect of this station. This is an activity which impacts primarily on the professional services but to some degree on every service of the station. It can be observed in many ways, the organization of the medical staff, the extent of the clinic services, the facilities needed on each nursing station, the number of residents and fellows on the staff, the designation as a RMEC center, the amount of space allocated to education and research, the number and types of specialized space in most clinical areas, the amount of in-referrals, the type of cases treated, etc. The amount of space and the relationships of one service to another must give consideration to this characteristic in order to accommodate the function of the building to the organization and daily activity of the patients and staff.

A second characteristic is the organization of the station, particularly the medical staff organization. The basic organization follows appropriate VA hospital system organization patterns. However, the medical staff organization appears to be a highly specialized one based on subspecialties in the major services of medicine and surgery. This subspecialty or superspecialty organization is superimposed on the basic VA hospital system organization. The effect of this characteristic is the organization of staff offices and their relationship to specialized service areas and to certain professional services. Proper such relationships will facilitate the operation of the staff and station.

A third characteristic is the station's relationship to the University of Minnesota School of Medicine. This is a very integrated relationship with much cross staffing and interaction of staff and students. The VAMC - Minneapolis is a major service/teaching institution within the total medical school program.

The way in which this station has developed is still another characteristic to be considered. What started as a "typical" VA hospital and which developed as a "prototype" VA hospital in the early 50s has, over the ensuing years, developed into its present form which has many of the characteristics of a university teaching hospital rather than a "typical" VA hospital. Many of the features of the existing facilities have been developed in response to specific and special needs--special labs and services, clinical research labs, resident study areas and team areas, animal research labs, etc. A reputation for excellence has been attained in several areas such as neurosurgery, neurology, kidney transplant and oncology. This is the result of both the staff excellence and commitment and the commitment of the VA to provide facilities and staff in support of these programs. It has been apparent to the Ellerbe staff that the station staff recognizes these needs and that to continue their existing level of service and development, they will need facilities organized in a similar manner to that which has been developed on a project basis over the years.

The VAMC - Minneapolis is designated as a regional center for the VA system in the upper midwest area. This requires an additional administrative staff and some modifications in several of the station services. Perhaps the greatest impact is felt in the number of in-referrals for specialized medical care and the special services and programs developed at this station.

Space Summary - Project Plan

The MCPS staff of the VACO has generated the space program used in this study. The basis of the study is trial 4 of the computer generated program. This program is based on approved VA criteria and appropriate draft criteria. Projected bed configurations, outpatient case loads and staffing patterns to the year 1985 have been applied to the criteria in order to generate the basic space program. To this have been added appropriate space allowances for approved special medical programs.

A part of the study effort has been to review the space program with the station and central office staff. This has been a joint activity with the MCPS planner. This review has indicated certain reallocation of the total space program and in some cases the need to add space for certain special areas not covered by either criteria or approved special medical programs. It is uncertain at this time whether or not these space allowances will finally be approved but they have been added to the trial 4 version of the space program because they are already existing spaces and services at this station or are logical extensions of existing services, i.e., GRECC program development.

These additions and modifications to the trial 4 version of the space program will be considered and incorporated in a trial 5 version to be developed after selection of a concept from this study. The trial 5 version may be affected by the concept selected, i.e., what type of beds are to remain in building 43 or is the basic dietetic service to remain in building 43. The selected concept will then be developed on the basis of the trial 5 version. The effort in this study, required because of the tight planning schedule, has been to anticipate the probable changes to be incorporated in the final, trial 5 version of the space program. While approval of some of the space allocation additions is uncertain, it is our impression that the changes from the modified trial 4 version used in this study will not be major and will not have a significant impact on any concept development.

PROGRAM CONCEPTS

As noted in the previous section, the trial 4 version of the Space Summary - Project Plan which was modified to anticipate probable changes, has been the basis for this study of concept alternatives. The trial 4 version is an alphabetical listing of the various services and does not in itself suggest groupings or relationships of services. Desired groupings or relationships have been determined from four sources:

1. The working relationship with the VACO staff has provided information as to appropriate, important, or essential relationships or locations of various services.

2. The opportunity to participate in reviews of the space program with station personnel has also given guidance to present operating relationships and to desired improvements in those relationships.

3. The functional relationships chart and the VA published criteria supplied by the HCPS staff have served as reference documents for desired groupings or relationships.

4. A relationships survey was conducted among all station services and provided information as to each service's relationship to:

    a. Other services
    b. Inpatient care
    c. Outpatient care
    d. Traffic routes and vertical circulation.

The modified Space Summary - Project Plan was summarized as a working document for the planning staff. The purpose of this summary, in addition to providing a "tool" for the planning staff, was to (1) show logical groupings of the various services, (2) develop subgroupings within some services which might guide a split or two-site location of a service if indicated (i.e., an outpatient pharmacy near the clinics and an inpatient pharmacy serving the nursing units), (3) apply net to gross factors normally used by Ellerbe and (4) reallocate spaces such as nursing unit support space, lounges, lockers, toilets and showers (LLTS), residents' offices and study areas, etc., which are programmed as a block area but are to be used in various areas as needed.

The summaries of the modified Space Summary - Project Plan are presented in the following pages as a reference during consideration of the concept alternatives. The first version is of the total space program as generated by the HCPS and serves as the space program for Concept C, Alternative I--the complete replacement of all station facilities. The other versions of the program are presented as the basis for the other concept alternatives and indicate primarily the spaces to be located in building 43 rather than in any new facilities constructed.

As may be noted, these summaries suggest an initial grouping of services into the major groups of:

a. Nursing Units
b. Diagnostic and Treatment Services
c. Clinic Areas
d. Special Professional Services
e. Research
f. Support Services

These groupings rather quickly developed into an ABC grouping which are the major blocks of building space.

A - Ancillary Services, both Diagnostic and Treatment and Support Services

B - Beds or Nursing Units

C - Clinics

These ABC blocks are apparent in each of the concepts presented in this study report.

VAMC - MINNEAPOLIS
SPACE ALLOCATION PROGRAM
SUMMARY RECAPITULATION

	NET SQUARE FEET	GROSS SQUARE FEET	
Nursing Units	198,192		303,764 FGSF*
Diagnostic and Treatment Services	141,891	196,579 DGSF*	
Clinic Services	90,962	128,829 DGSF	
Special Professional Services	45,561	60,126 DGSF	
Research	69,436	90,267 DGSF	
Support Services	161,021	188,462 DGSF	
Subtotal	707,063	664,263 DGSF	
Circulation Allowance (x1.25)			830,329 FGSF
Subtotal			1,134,093 FGSF
Mechanical Systems Allowance (x1.08)			1,224,820 BGSF*
Existing VAMC Net Square Feet	641,017		

* DGSF - Departmental Gross Square Feet
FGSF - Floor Gross Square Feet
BGSF - Building Gross Square Feet

SPACE ALLOCATION PROGRAM
SUMMARY
CONCEPT C

NURSING UNITS	BEDS	NET SQUARE FEET	GROSS SQUARE FEET
Medical	45	8,521	13,122
Medical	45	8,521	13,122
LLTS/Nursing Support (1)		1,680	2,587
Medical	45	8,521	13,122
Medical	45	8,696	13,392
LLTS/Nursing Support		1,680	2,587
Medical/SDTU	45	10,141	15,617
Neurology/GRECC	54	10,844	16,699
LLTS/Nursing Support		1,680	2,587
Surgical	45	8,521	13,122
Surgical	45	8,416	12,960
LLTS/Nursing Support		1,680	2,587
Surgical	45	8,416	12,960
Surgical/Neurosurgery	45	8,136	12,529
LLTS/Nursing Support		1,680	2,587
Orthopedic	37	7,417	11,422
Orthopedic/Head and Neck	37	7,557	11,638
LLTS/Nursing Support		1,680	2,587
Rehabilitation	30	6,584	10,139
Intermediate Medicine	30	6,134	9,446
LLTS/Nursing Support		1,680	2,587
Medical ICU	8	3,202	5,027
Coronary ICU	6	2,674	4,198
Surgical ICU	13	4,392	6,895
Transplant ICU	10	3,766	5,913
Psychiatry	30	7,922	11,566
Psychiatry	30	7,777	11,354
Chemical Dependence	30	7,617	11,121
LLTS/Nursing Support		1,680	2,587
Nursing Home	60	11,259	17,339
Nursing Home	60	10,725	16,516
Nursing Home - Central Facility	___	8,993	13,849
TOTAL	840	198,192	303,764
Hemodialysis	10		
TOTAL	850		

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(1) LLTS - Lounges, Lockers, Toilets and Showers
Nursing Support - Pharmacy Med Prep, X-Ray Storage, BMS Storage, Visitor Facilities

SPACE ALLOCATION PROGRAM
SUMMARY

DIAGNOSTIC AND TREATMENT SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Surgical Service (Operating Rooms)	25,921	39,134
Inpatient Procedure Rooms	10,050	15,276
Cystoscopy Rooms	1,050	1,596
Ambulatory Procedure Rooms/Support	3,306	5,025
Recovery Rooms	5,253	7,985
Support Areas	3,336	4,804
Anesthesia Support Areas	1,140	1,733
Dressing Rooms and On Call Rooms	1,706	2,715
Laboratory Service	32,014	41,299
Anatomic Pathology	4,868	6,280
Clinical Laboratory	21,658	27,939
Specimen Collection	810	1,045
Blood Bank	1,548	1,997
Electron Microscopy	800	1,032
Autopsy	2,030	2,619
Remote Storage	300	387
Diagnostic Radiology Service	19,279	27,952
Administrative Areas	3,150	4,567
Procedure Rooms		
General	4,790	6,945
Special, Ultrasound, CRT	2,730	3,958
Reading/Interpretation Rooms	4,385	6,358
Support Areas	2,764	4,008
Clinic Satellite	1,460	2,117
Radiation/Supervoltage Therapy	4,123	5,731
Nuclear Medicine	7,498	10,497
EEG/EMG	4,798	6,717
Pulmonary Service	4,210	5,787
Medical Staff Offices	1,070	1,391
Pulmonary Function Labs	1,300	1,820
Bronchoscopy Areas	1,370	1,918
Inhalation Therapy	470	658
Endoscopy/Gastrointestinal Lab	4,590	6,247
Offices Area	1,790	2,327
Procedure Rooms/Support	2,800	3,920
EKG/Clinical Cardiac Lab	7,002	9,803
EKG Service	1,925	2,695
Offices/Education Areas	2,468	3,455
Clinical Cardiac Lab	2,609	3,653

DIAGNOSTIC AND TREATMENT SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Rehabilitation Medicine Service	14,820	19,118
Inpatient Service	6,780	8,746
Outpatient Service	1,120	1,445
Recreation Therapy	3,980	5,134
Psychiatry Service	2,620	3,380
LLTS	320	413
Audiology	2,970	4,158
Speech Pathology	1,835	2,569
Pharmacy	12,831	17,566
Inpatient Pharmacy	4,225	6,636
Ambulatory Care Pharmacy	7,606	9,660
Special Programs	1,000	1,270
TOTAL	141,891	196,579

SPACE ALLOCATION PROGRAM
SUMMARY

CLINIC SERVICES		NET SQUARE FEET	GROSS SQUARE FEET
Ambulatory Care Service		28,300	40,469
Administration		1,014	1,450
General Waiting/Control		4,444	6,355
Medical "Clusters"	5	10,982	15,705
Surgical "Clusters"	3	6,562	9,383
Gastrointestinal "Cluster"	1	2,544	3,638
Urology "Cluster"	1	2,754	3,936
Evaluation and Emergency		10,300	14,729
General Waiting/Control		1,973	2,821
Admissions/Clerical		2,870	4,104
Emergency and Observation		3,115	4,454
Evaluations "Clusters"	2	2,342	3,349
Eye-ENT Clinic		3,169	4,531
Eye Clinic Area		1,200	1,716
ENT Clinic Area		910	1,301
Offices, etc.		1,059	1,514
Dental Service		10,577	14,808
General Treatment Area		5,062	7,087
Special Treatment Area		2,154	3,016
Dental Laboratories		1,711	2,395
Offices/Education Areas		1,650	2,310
GRECC - Clinical Area		8,174	10,626
Hospital Based Home Care		1,710	2,220
Hemodialysis Center		6,086	9,372
Home Dialysis/Limited Care Dialysis		5,663	8,721
Prosthetics		3,274	4,223
Drug Dependence Clinic		2,030	2,903
Outpatient Psychiatry		8,030	11,483
Offices, etc.		4,320	6,178
Activity Areas		3,710	5,305
Day Hospital		3,649	4,744
Offices, etc.		1,370	1,781
Activity Areas		2,279	2,963
TOTAL		90,962	128,829

SPACE ALLOCATION PROGRAM
SUMMARY

SPECIAL PROFESSIONAL SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Alcohol/Drug Service	874	1,136
Psychiatric Service	914	1,188
Psychology Service	4,712	6,126
Central Offices	3,812	4,956
Computer Testing	900	1,170
Medical Service	11,870	15,431
Administration	510	663
Subspecialty Services		
Cardiovascular	1,930	2,509
Gastrointestinal	see Endoscopy	
Hematology	2,330	3,029
Infectious Diseases	1,790	2,327
Nephrology	880	1,144
Dermatology	see Clinics	
Psychological Medicine	1,210	1,573
Pulmonary	see Pulmonary Service	
Ambulatory Care	see Clinics	
Metabolic/Endocrine	1,860	2,418
Rheumatology	1,360	1,768
Neurology Service	4,750	6,175
Offices, etc.	1,910	2,483
Parkinsonian Lab	350	455
Behaviorial Lab	400	520
Aphasia Lab	770	1,001
Neuro Genetics Lab	240	312
Epilepsy Treatment Center	1,080	1,404
Surgical Service	2,620	3,406
Administration	510	663
Subspecialty Services		
General Surgery	1,240	1,612
Neurosurgery	240	312
Anesthesia	630	819
Orthopedic	see Ortho Nursing Units	
Urology	see Clinics	
ENT	see Clinics	
Ophthalmology	see Clinics	
Medical Illustration Service	1,875	2,437
Education Center	6,518	8,799
Offices, etc.	1,398	1,887
CCTV Studio	1,120	1,512
Auditorium	4,000	5,400

SPECIAL PROFESSIONAL SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Library Service	11,428	15,428
Health Science Library	7,216	9,742
Study Carrels	1,800	2,430
Conference/Workroom	1,637	2,210
Patient Library/Education	775	1,046
TOTAL	45,561	60,126

SPACE ALLOCATION PROGRAM
SUMMARY

RESEARCH	NET SQUARE FEET	GROSS SQUARE FEET
Laboratories, Common Instrument Rooms, Lab Support/Offices	37,803	49,144
Miscellaneous Spaces/Storage	6,550	8,515
Administrative	2,743	3,566
Animal Space	22,340	29,042
TOTAL	69,436	90,267

NOTE: This space program is based on the replacement of all existing Research space, including Building 49. The net square foot data and classification is taken from the Station Space Inventory. The Ellerbe net to gross factor was applied to estimate the gross square footage requirements.

Of the above space, Building 49 net square footage includes:

Laboratories, et al	15,950
Miscellaneous/Storage	1,340
Administrative	2,054
Animal Space	2,996
TOTAL	22,340

SPACE ALLOCATION PROGRAM
SUMMARY

SUPPORT SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Voluntary Service	1,075	1,236
Chaplain Service	4,033	4,731
Chapel	2,560	2,816
Offices, etc.	1,473	1,915
Hospital Directors Suite	2,908	3,780
Offices, etc.	2,008	2,610
Conference Rooms	900	1,170
Fiscal Service	2,456	3,392
Medical Administrative Service	12,866	17,755
Administration/Admissions	2,068	2,854
Medical Information	4,738	6,538
Fee Services	1,700	2,346
Ward Administration	270	373
Office Operations	3,394	4,684
Medical Records Storage	696	960
Service Organizations	480	624
Veterans Assistance	240	312
Building Management Service	9,277	10,049
Offices, etc.	1,238	1,609
Storage	2,338	2,455
Linen Service	3,627	3,808
Trash Collection	200	210
Locker and Shower - Male	446	468
- Female	308	323
Housekeeping Aids Closets	1,120	1,176
Laundry	19,284	21,212
Receiving	1,834	2,017
Production	15,721	17,293
Support Areas	1,729	1,902
Receiving Dock		240
Lobby	901	991
Supply Service	45,684	50,712
Administration	2,830	3,679
Supply, Processing, Distribution	20,370	23,425
Warehouse	22,484	23,608
Receiving Dock		660

SUPPORT SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Engineering Service	15,215	17,497
Offices/Education/Drafting	2,393	2,752
Shop Areas		
Biomedical Engineering	1,620	1,863
Trades	10,474	12,045
Groundskeeping	728	837
Covered Outside Storage		400
Nursing Service Administration	2,240	2,688
Offices, etc.	1,130	1,356
Education and Training	1,110	1,332
Dietetic Service	16,947	19,828
Offices/Education	2,738	3,203
Central Tray Service	3,598	4,210
Sanitation	1,859	2,175
Food Preparation	7,004	8,195
Staff Dining	300	351
Locker and Shower - Male	429	502
- Female	699	818
Nutrition Clinic	320	374
Canteen Service	17,457	20,425
Office	240	281
Retail Store	2,300	2,691
Cafeteria		
Food Production	5,803	6,790
Dining Room	7,644	8,943
Vending	900	1,053
Lockers and Toilets	340	398
Barber Shop	230	269
Quarters Resident (On Call)	2,019	2,423
Bedrooms	1,600	1,920
Lounges/Support	419	503
Credit Union	310	372
Personnel Service	2,364	2,837
Social Work Service	5,130	6,156
Offices and Activity Areas	3,690	4,428
Education Space	1,440	1,728
Waste Disposal	135	142

SUPPORT SERVICES	NET SQUARE FEET	GROSS SQUARE FEET
Trash and Garbage	0	0
Boiler Plant	0	0
TOTAL	161,021	188,462

SPACE ALLOCATION PROGRAM
SUMMARY
CONCEPT A

	Net Square Feet	Building 43 Gross Square Feet			
Nursing Units	61,854			95,675	FGSF
Diagnostic & Treatment Services	47,752	67,458	DGSF		
Clinic Services	0	0	DGSF		
Special Professional Services	18,495	24,043	DGSF		
Research	(89,436)	(90,267)	DGSF		
Support Services	63,719	77,167	DGSF		
Subtotal	191,820	168,668	DGSF		
Circulation Allowance		24,374	DGSF	193,042	FGSF
Subtotal				288,717	FGSF
Mechanical Systems Allowance (x 1.08)				311,814	BGSF

( ) - not included in totals since research will remain in existing facilities.

	Net Square Feet	New Construction Gross Square Feet			
Nursing Units	132,032			201,704	FGSF
Diagnostic & Treatment Services	94,139	129,121	DGSF		
Clinic Services	90,962	128,829	DGSF		
Special Professional Services	37,066	36,083	DGSF		
Research	0	0	DGSF		
Support Services	97,302	111,295	DGSF		
Subtotal	441,501	405,328	DGSF		
Circulation Allowance (x 1.25)				506,660	FGSF
Subtotal				708,364	FGSF
Mechanical Systems Allowance (x 1.08)				765,033	BGSF
Total Building 43 and New Construction				1,076,847	BGSF
Plus Research				1,190,707	BGSF

SPACE ALLOCATION PROGRAM
SUMMARY
CONCEPT A

	BUILDING 43			NEW CONSTRUCTION		
	Beds	Net Square Feet	Gross Square Feet	Beds	Net Square Feet	Gross Square Fee
Medical	32	5,872	9,043			
Medical	32	5,872	9,043			
LLTS/Nursing Support		1,156	1,780			
Medical	33	6,056	9,326			
LLTS/Nursing Support		578	890			
Medical	32	5,872	9,043			
Medical	32	5,872	9,043			
LLTS/Nursing Support		1,156	1,780			
Medical ICU	8	3,202	4,675			
Coronary ICU	6	2,674	3,904			
Medical	32	5,872	9,043			
LLTS/Nursing Support			890			
Neurology	54	10,066	15,502			
LLTS/Nursing Support		1,156	1,780			
Medical	32	5,872	9,043			
LLTS/Nursing Support		578	890			
Surgical				45	8,521	13,122
Surgical				45	8,416	12,960
LLTS/Nursing Support					1,680	2,587
Surgical				45	8,416	12,960
Surgical/Neurosurgery				45	8,136	12,529
LLTS/Nursing Support					1,680	2,587
Orthopedic				37	7,417	11,422
Orthopedic/Head and Neck				37	7,557	11,630
LLTS/Nursing Support					1,680	2,587
Surgical ICU				13	4,392	6,895
Transplant ICU				10	3,766	5,913
Rehabilitation				30	6,584	10,139
Intermediate Medicine				30	6,134	9,446
LLTS/Nursing Support					1,680	2,587
Psychiatry				30	7,922	11,566
Psychiatry				30	7,777	11,354
Chemical Dependence				30	7,617	11,121
LLTS/Nursing Support					1,680	2,587
Nursing Home				60	11,259	17,339
Nursing Home				60	10,725	16,516
Nursing Home - Central					8,993	13,849
TOTAL	293	61,854	95,675	547	132,032	201,704
Hemodialysis				10		
				557		

SPACE ALLOCATION PROGRAM
SUMMARY

DIAGNOSTIC AND TREATMENT SERVICES	BUILDING 43 Net Square Feet	BUILDING 43 Gross Square Feet	NEW CONSTRUCTION Net Square Feet	NEW CONSTRUCTION Gross Square Feet
Surgical Service (Operating Rooms)			25,921	39,134
Laboratory Service			32,014	41,299
Diagnostic Radiology Service	17,819	25,838	1,460	2,115
Radiation/Supervoltage Therapy			4,123	5,731*
Nuclear Medicine	7,498	10,497		
EEG/EMG	4,798	6,717		
Pulmonary Service	4,210	5,787		
Endoscopy/Gastrointestinal Lab	4,590	6,247		
EKG/Clinical Cardiac Lab	7,302	9,803		
Rehabilitation Medicine Service			14,820	19,118
Audiology			2,970	4,158
Speech Pathology	1,835	2,569		
Pharmacy			12,831	17,566
TOTAL	47,752	67,458	94,139	129,121

*Will remain in its existing location

Clinic Services				
Ambulatory Care Service			28,300	40,469
Evaluation and Emergency			10,300	14,729
Eye - ENT Clinic			3,169	4,531
Dental Service			10,577	14,808
GRECC - Clinical Area			8,174	10,626
Hospital Based Home Care			1,710	2,220
Hemodialysis Center			6,086	9,372
Home Dialysis/Limited Care Dialysis			5,663	8,721
Prosthetics			3,274	4,223
Drug Dependence Clinic			2,030	2,903
Outpatient Psychiatry			8,030	11,483
Day Hospital			3,649	4,744
			90,962	128,829

Special Professional Services				
Alcohol/Drug Service			874	1,136
Psychiatric Service			914	1,188
Psychology Service			4,712	6,126
Medical Service	11,870	15,431		
Neurology Service	4,750	6,175		
Surgical Service			2,620	3,406
Medical Illustration Service	1,875	2,437		
Education Center			6,518	8,799
Library Service			11,428	15,428
TOTAL	18,495	24,043	27,066	36,083
Research	69,436	90,267*		
TOTAL	69,436	90,267		

*To remain in existing facilities, Building 49, 31, etc.

	BUILDING 43		NEW CONSTRUCTION	
DIAGNOSTIC AND TREATMENT SERVICES	Net Square Feet	Gross Square Feet	Net Square Feet	Net Square Feet
Support Services				
Voluntary Service	1,075	1,236		
Chaplain Service	4,033	4,731		
Hospital Director's Suite	2,908	3,780		
Fiscal Service	2,456	3,392		
Medical Administrative Service	6,060	8,363	6,806	9,392
Service Organizations	480	624		
Veterans Assistance	240	312		
Building Management Service			9,277	10,049
Laundry			19,284	21,212
Receiving Dock				240
Lobby			901	991
Supply Service			45,684	50,712
Receiving Dock				660
Engineering Service			15,215	17,497
Covered Outside Storage				400
Nursing Service Administration	2,240	2,688		
Dietetic Service	16,947	19,828		
Canteen Service	17,457	20,425		
Quarters Resident	2,019	2,423		
Credit Union	310	372		
Personnel Service	2,364	2,837		
Social Work Service	5,130	6,156		
Waste Disposal			135	142
Trash and Garbage			0	0
Boiler Plant			0	0
TOTAL	63,719	77,167	97,302	111,295

SPACE ALLOCATION PROGRAM
SUMMARY
CONCEPT B

	Net Square Feet	Building 43 Gross Square Feet			
Nursing Units	24,996			36,628	FGSF
Diagnostic & Treatment Services	5,871	7,556	DGSF		
Clinic Services	27,168	39,443	DGSF		
Special Professional Services	9,773	12,774	DGSF		
Research	69,436	90,267	DGSF		
Support Services	55,911	63,574	DGSF		
Subtotal	193,155	213,614	DGSF		
Circulation Allowance (x 1.25)				267,018	FGSF
Subtotal				303,646	FGSF
Mechanical Systems Allowance (x 1.08)				327,938	BGSF

	Net Square Feet	New Construction Gross Square Feet			
Nursing Units	173,196			267,136	FGSF
Diagnostic & Treatment Services	136,020	189,023	DGSF		
Clinic Services	63,794	89,386	DGSF		
Special Professional Services	35,788	47,352	DGSF		
Research	0	0	DGSF		
Support Services	105,110	124,882	DGSF		
Subtotal	513,908	450,643	DGSF		
Circulation Allowance (x 1.25)				563,304	FGSF
Subtotal				830,440	FGSF
Mechanical Systems Allowance (x 1.08)				896,875	BGSF
Total Building 43 and New Construction				1,224,813	BGSF

SPACE ALLOCATION PROGRAM
SUMMARY
CONCEPT B

	BUILDING 43			NEW CONSTRUCTION		
Nursing Units	Beds	Net Square Feet	Gross Square Feet	Beds	Net Square Feet	Gross Square Fe
Medical				45	8,521	13,122
Medical				45	8,521	13,122
LLTS/Nursing Support					1,680	2,587
Medical				45	8,521	13,122
Medical				45	8,696	13,392
LLTS/Nursing Support					1,680	2,587
Medical/SDTU				45	10,141	15,617
Neurology/GRECC				54	10,844	16,699
LLTS/Nursing Support					1,680	2,587
Surgical				45	8,521	13,122
Surgical				45	8,416	12,960
LLTS/Nursing Support					1,680	2,587
Surgical				45	8,416	12,960
Surgical/Neurosurgery				45	8,136	12,529
LLTS/Nursing Support					1,680	2,587
Orthopedic				37	7,417	11,422
Orthopedic/Head and Neck				37	7,557	11,636
LLTS/Nursing Support					1,680	2,587
Rehabilitation				30	6,584	10,139
Intermediate Medicine				30	6,134	9,446
LLTS/Nursing Support					1,680	2,587
Medical ICU				8	3,202	5,027
Coronary ICU				6	2,674	4,198
Surgical ICU				13	4,392	6,895
Transplant ICU				10	3,766	5,913
Psychiatry	30	7,922	11,566			
Psychiatry	30	7,777	11,354			
Chemical Dependency	30	7,617	11,121			
LLTS/Nursing Support		1,680	2,587			
Nursing Home				60	11,259	17,339
Nursing Home				60	10,725	16,516
Nursing Home - Central					8,993	13,849
TOTAL	90	24,996	36,628	750	173,196	267,136
Hemodialysis	10 100					

Concept B--contd.

	Building 43		New Construction	
Diagnostic & Treatment Services	Net Square Feet	Net Square Feet	Net Square Feet	Net Square Feet
Surgical Service (Operating Rooms)			25,921	39,134
Laboratory Service	2,330	3,006	29,684	38,293
Diagnostic Radiology Service			19,279	27,953
Radiation/Supervoltage Therapy			4,123	5,731*
Nuclear Medicine			7,490	10,497
EEG/EMG			4,798	6,717
Pulmonary Service			4,210	5,787
Endoscopy/Gastrointestinal Lab			4,590	6,247
EKG/Clinical Cardiac Lab			7,002	9,803
Rehabilitation Medicine Service	2,620	3,380	12,200	15,738
Audiology			2,970	4,158
Speech Pathology			1,835	2,569
Pharmacy	921	1,170	11,910	16,396
TOTAL	5,871	7,556	136,020	189,023

*Will remain in it's existing location.

Clinic Services				
Ambulatory Care Service			28,300	40,469
Evaluation & Emergency			10,300	14,729
Eye-ENT Clinic			3,169	4,531
Dental Service			10,577	14,808
GRECC-Clinical Area			8,174	10,626
Hospital Based Home Care	1,710	2,220		
Hemodialysis Center	6,086	9,372		
Home Dialysis/Limited Care Dialysis	5,663	8,721		
Prosthetics			3,274	4,223
Drug Dependence Clinic	2,030	11,483		
Day Hospital	3,640	4,744		
TOTAL	27,168	39,443	63,794	89,386
Special Professional Services				
Alcohol/Drug Service	874	1,136		
Psychiatric Service	914	1,188		
Psychology Service	4,712	6,126	Same offices in other dept	
Medical Service			11,870	15,431
Neurology Service			4,750	6,175
Surgical Service			2,620	3,406
Medical Illustration Service	1,873	2,437		
Education Center	1,398	1,887	5,120	6,912
Library Service			11,428	15,428
TOTAL	9,773	12,774	35,788	47,352
Research	69,436	90,267		
TOTAL	69,436	90,267	0	0

Concept B--contd.

	Building 43		New Construction	
Diagnostic & Treatment Services	Net Square Feet	Net Square Feet	Net Square Feet	Net Square Feet
Support Services				
Voluntary Service	1,075	1,236		
Chaplain Service	2,222	2,600	1,811	2,131
Hospital Director's Suite			2,908	3,780
Fiscal Service			2,456	3,392
Medical Administrative Service			12,866	17,755
Service Organizations			480	624
Veterans Assistance			240	312
Building Management Service	5,499	6,049	3,778	4,000
Laundry			19,284	21,212
Receiving Dock				240
Lobby			901	991
Supply Service	25,314	27,947	20,370	22,765
Receiving Dock				660
Engineering Service			15,215	17,497
Covered Outside Storage				400
Nursing Service Administration			2,240	2,688
Dietetic Service	13,397	15,675	3,550	4,153
Canteen Service	600	702	16,857	19,723
Quarters Resident			2,019	2,423
Credit Union	310	372		
Personnel Service	2,364	2,837		
Social Work Service	5,130	6,156	some office in other departments	
Waste Disposal			135	142
Trash and Garbage			0	0
Boiler Plant			0	0
TOTAL	55,911	63,574	105,110	124,882

The bed configuration approved for use in this study is as follows:

Internal Medicine		249
Intermediate Medicine		26
Surgery		277
Rehabilitation Medicine		29
Neurology - Acute	38	
- Nonacute	16	54
Psychiatry- Acute	65	
- Nonacute	25	90
Total		725

In addition, a 120-bed nursing home is to be included in the study for a total of 845 beds.

It should be noted that the Intermediate Medicine and Rehabilitation Medicine allocations are below the minimum nursing unit size of 30 beds, and both are units which should be autonomous because of the nature or level of care provided. Accordingly, it was authorized to increase each unit to 30 beds, increasing the total bed complement to 850 beds.

Another factor to be noted is the acute/nonacute designation of beds in the Neurology and Psychiatry Services. In both cases, the number of beds is below the minimum nursing unit size. The interpretation used in this study is that these beds will be incorporated with the acute care beds and that the modification to nonacute care services will be one of professional judgment and staffing. There is no apparent space programming difference between acute and nonacute care beds.

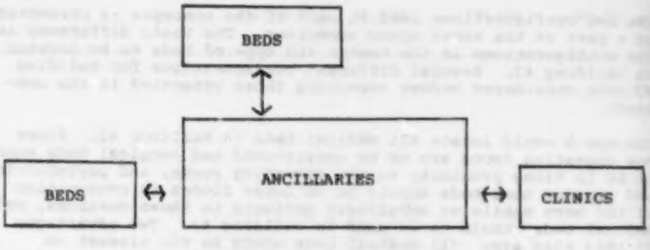
The bed configurations used in each of the concepts is presented as a part of the above space summaries. The basic difference in the configurations is the number and type of beds to be located in building 43. Several different configurations for building 43 were considered before accepting those presented in the concepts.

Concept A would locate all medical beds in building 43. Since new operating rooms are to be constructed and surgical beds ought to be in close proximity to the operating rooms, and psychiatric and nursing home beds should be on lower floors in recognition of the more mobile or ambulatory patients in these services, only medical beds remain to be used in building 43. Two advantages of this plan are: (1) medical beds would be the closest to diagnostic radiology and are, we are informed, the largest "user" of radiology exams and (2) of the three existing nursing units per floor, only two will be used as nursing units. The third will be used as programmed support space for the other two. In most cases, this will allow subspecialty service space to be located on these floors--a pattern which seems to "fit" the Medical Service organization.

Concept B uses a different configuration of beds in building 43. Three psychiatric and chemical dependence nursing units would be located in this building; all other beds would be in new construction. An alternative considered would be to locate psychiatric and chemical dependence plus intermediate, rehabilitation and nursing home beds in building 43.

The ABC blocks mentioned above are a general guide to the relationships developed in the concepts. Clinic patients and staff (C block) utilize the diagnostic and treatment services and support services (A block) in varying degrees but in a manner which emphasizes rapid access to and rapid reporting from the services. If feasible, a horizontal relationship between the C block and A block will facilitate operations and ease the traffic of clinic patients to the diagnostic services. The diagnostic and treatment and support services (A block) also serve the nursing units or beds (B block). Generally either horizontal or vertical relationships are satisfactory. The choice between horizontal and vertical usually depends on site considerations and structural systems relative to the importance of horizontal relationships such as surgical beds to operating rooms or rehabilitation beds to rehabilitation medicine services. Generally speaking, we favor the horizontal relationships for the VAMC - Minneapolis but recognize that the vertical relationships such as in building 43 are very acceptable.

Diagrammatically, these relationships may be shown as follows:



Horizontal relationships generally seem to fit the professional organization of the VAMC - Minneapolis. Members of the medical staff, differing from a private practice situation, have their offices within the hospital building. Many of the subspecialty staff have specialty labs or patient exam areas which ideally should be located in close proximity to their offices. Or, these physicians have an administrative and/or professional responsibility for a diagnostic or treatment department where they should be located. Most staff members have patient care and teaching responsibilities which require their frequent presence on the nursing units. Therefore, it appears that a horizontal relationship of these elements would facilitate their operating activities.

BEDS ←→ SPECIALTY SERVICES ←→ OFFICES

Many of these staff members and their patients also use the clinic areas. A horizontal relationship of the above areas and the clinics would be good. But, it would also tend to force a three or four-level clinic.

Resident and medical student office and studyspace is allocated in varying ways according to the teaching and patient care responsibilities in each service. Most of the services have organized their teaching program on a "team" basis with each team consisting of one or two residents and a medical student. Most services need space allocated for 3-4 such teams per nursing unit. Other residents may have primary responsibility in the clinics or specialty areas and need office and study space in those areas. Educational space allocations have been reallocated to conform with these needs.

The Ambulatory Care Service space program suggests two major subgroups--an Evaluation and Emergency Service and a Clinic Area. These two major subgroups have been maintained. But the clinic area has been further subdivided in order to organize this space in a manner which will serve the variety of clinics now provided. We have chosen to call this organization of space a cluster concept.

The station now conducts some 100-120 half-day clinic sessions per week in addition to psychiatric and EENT clinics. These are conducted in a variety of locations--building 43, building 3, building 5, building 6, at Fort Snelling, and perhaps others. Each clinic half-day session serves between 3 and 50 patients. Some consolidation of these sessions would seem possible if all clinic space were consolidated in one location as is planned in this study project. This consolidation of clinic sessions was not investigated with the professional staff. It would appear then that ten clinic clusters would serve adequately to accommodate the clinic schedule. Any one cluster might serve different clinic sessions, i.e., Cardiology on Monday and Wednesday, Hematology on Tuesday, Stress on Thursday, and Geriatric on Friday.

Each cluster should include waiting and clerical space plus a complement of exam rooms, consultation rooms, treatment rooms, residents' study/conference rooms and support space. The number of exam rooms per cluster was the most significant criteria. The ten clusters were allocated as follows:

1 - 10 exam rooms--to serve high volume specialty clinics
2 - 8 exam rooms--to serve high volume general clinics
5 - 6 exam rooms--to serve specialty clinics
1 - 6 exam rooms--to serve gastrointestinal and related clinics
1 - 6 exam rooms--to serve the urology clinic.

The general concept would provide a central waiting and reception area on each clinic floor for receiving all patients. Any registration, scheduling, cashiering, educational and similar activities would be conducted in this area. When these activities were completed and at the proper time, the patient would be referred to the waiting area of the appropriate cluster. From this point, the patient would be accommodated in the clusters' exam and treatment rooms.

Clinic clusters could be arranged in a variety of ways--all on one floor, according to medical and surgical services, according to general and specialty clinics, according to available space, etc.

To accommodate existing operations, the urology cluster must be located adjacent to the cystoscopy rooms which in turn must be located as a part of the operating room suite. The staff of this service moves freely and frequently between clinic areas and diagnostic and operative cystoscopy rooms. This clinic cluster must be treated separately.

Several services, notably psychology, dietetics, and social work, find it best if some of their staff are officed in other service areas, i.e., psychologists on each psychiatric nursing unit, social workers on each nursing unit and in the clinic areas, etc. These reallocations have been made to the extent known. Further such reallocations will probably be necessary during the design development phase of planning when the design concept has been established, interdepartmental relationships are apparent, and staff personnel have the opportunity to review departmental design.

In other services, the detail of the space program and the relationship information gained from several sources suggest that portions of some departments should or might be designed in certain configurations or in separate locations. Such changes have been considered in varying ways during concept development. Illustrations of such programming concepts are:

a. The operating rooms will utilize a peripheral corridor design scheme.

b. The anatomical pathology section of the laboratory service would be located adjacent to the operating rooms.

c. Audiology and speech pathology were separated into two functional areas with audiology to be located in close proximity to the ENT clinic and speech pathology to be located near the neurology service.

d. The pharmacy space may be divided in two areas--outpatient pharmacy serving the clinic area and inpatient pharmacy serving the inpatient nursing units.

e. A radiology satellite may be located in the clinic area if the total radiology service is not located close to the clinics.

f. Other space subdivisions as indicated in the space program summaries.

Most support services are located as one total contiguous block of space except for the supply service in whichthe SPD section may be separate in order to locate it with good access to the operating rooms.

This section has described the major concepts and interpretations of program which have been used in the study project. Relatively minor clarifications and changes in these programming concepts must be expected during design development but such changes are not likely to alter the basic concepts presented in this study.

CONCEPT DEVELOPMENT

Several analyses were performed as background for the development of the concepts presented in the next section of this report. These analyses pertain either to all of the concepts or to other concepts considered and rejected.

Site Considerations

The present VAMC site is a park-like setting bordering on residential areas on two sides and highways and the airport on the other two sides. The site has a slight slope down to the south and to the east. The site is bisected by Minnehaha Avenue with the main hospital buildings to the west and residences, research and boiler plant/laundry to the east.

Minnehaha Avenue is the main access to the hospital site though there are secondary entrances from the residential streets.

Open areas of the site are to the south of the original and present hospital buildings. The primary orientation of the buildings (main entrance) is to the north which creates a somewhat confusing situation to persons entering the site from Minnehaha Avenue.

Climatic conditions, pleasant but warm summers and severe winters, require special considerations both air conditioning in the summer months and protection from the northwesterly winds and snow in the winter. Sun and wind conditions suggest a south by southeasterly orientation with taller buildings to the northwest and patient areas to the south and southeast.

Site development should incorporate the following features:

1. Minnehaha Avenue should continue to be the primary access to the hospital buildings with the residential streets to continue as secondary access roads. The entry point should should be close as possible to the existing entrance.

2. Parking should be developed to the east and near the front entrance for patients and visitors and to the west and north for staff.

3. Open space and "green" space should be developed at the front entrance and to the south.

4. Nursing units, especially the nursing home and longer term care units, should be positioned to the south to take advantage of the open space vistas and to avoid traffic noise from Minnehaha Avenue. Various types of outdoor space should be developed to support both passive and active activities.

5. Boiler plant and laundry buildings are located in the east section of the site and should remain in that section though new buildings should be built closer to the hospital and west of the proposed highway construction.

6. Buffer zones of vegetation should be developed around the periphery of the site to:

   a. block winter winds from the northwest;
   b. block parking lots from residential areas;
   c. reduce the impact of Minnehaha Avenue and Crosstown highway traffic;
   d. create interesting pedestrian pathways.

Siting Considerations - Heating-Cooling Plant, Laundry, Fire Station, Vehicle and Equipment Storage

The recommendations by central office staff for the site east of Minnehaha Avenue have been tested against the advisability of siting the plant closer to the hospital. We concur in the original selection for several reasons.

The addition of a laundry facility capable of serving the Minneapolis and St. Cloud Site will generate traffic which we feel can best be confined to the off-site location east of Minnehaha Avenue.

Truck traffic for fuel delivery and the potential of additional vehicular traffic, maintenance vehicles and fire equipment led us to favor the site east of the immediate hospital site. It was also felt that the complex envisioned would be less compatible with the residential neighborhood on the west and north and would intrude on the park-like setting of the station, particularly the south half.

Contiguous Location to Building 43

Initial consideration was given to new construction locations contiguous to Building 43 in order to develop a compact scheme with short and efficient internal travel distances. Such a location encounters substantial problems.

A logical location is in the present Building 1 and 2 area. Major phasing problems are immediately presented but can be solved by initial construction to replace these buildings to the west of Building 43. An acceptable phasing scheme can be developed but requires a longer time to complete the total program.

The design of Building 43 limits the number of points at which new construction can be connected to Building 43 without forcing traffic through an existing nursing unit.

Floor-to-floor heights are perhaps the most severe problem. Building 43 heights are 11'-0" and 11'-11" on mort floors. Minimal heights for current mechanical systems are 15' for Ancillary Department floors and 13' for nursing unit floors. An interstitial space system would require even greater heights.

Mechanical systems would probably have to be separate from Building 43. Building 43 is not air conditioned and it is doubtful that a central system could be developed in this building.

The service entrance possible in a "tight" connection is small but acceptable in size. The proposed location maintains the present entrance and is a good location.

Since new construction to the west of Building 43 occupies most of the available site in this area, it limits the amount of parking space which can be developed in this area.

Consideration was given to locating various types of facilities, clinics, nursing home, service and total new construction, to the east of Building 43. These were not considered acceptable for several reasons -

- the site is limited in size in this area;
- facilities in this area would be close to traffic noise on Minnehaha Avenue;
- construction of selected areas such as the clinics in this area would "wrap" new construction around older buildings and would place these areas a long distance from ancillary services developed to the west;
- construction in this area would limit the space available to develop a proper main entry and approach to that entry and would force parking to the south.

Phasing Considerations

Initial considerations of various concepts concentrated on locations close to Building 43 and between Building 43 and 49. Concept B, a location away from Building 43, developed later in response to the problems associated with construction tied to Building 43.

Phasing problems are an immediate problem in any scheme tied closely to Building 43. For example, a logical site for replacement construction is Building 1. But to make this site available, both a substantial number of beds must be built and several ancillary services, notably the Laboratory Service and Nuclear Medicine, must be built. There is no temporary facility of sufficient size to accommodate all of the services in Building 1 during the demolition and construction phase.

A related problem is the access to Building 2 which includes the canteen and several administrative and professional services. The only internal access to Building 2 is through Building 1. To build in the Building 1 area would require either that Building 2 services also be replaced before the site is available or that an indirect temporary connector be constructed from Building 2 to Building 43.

Our study indicated that the only feasible construction area close to Building 43 is to the west of Building 43 and 1. This creates two major phasing problems in that the Education Building and Building 3 are located in this area. Several temporary buildings and the existing oval connector are also in this area. The temporary buildings do not seem to be a major problem and a temporary connector could be constructed. The Education Building is primarily classrooms and offices. If space cannot be found within existing buildings (we are not aware of such space), a manufactured building could be installed for this temporary use. For the construction period, it would seem that a medical unit could be moved to Building 7, currently unoccupied and the urolcgy service moved to that vacated medical unit.

Another phasing problem is the station's need to consolidate and expand clinic areas in the near future. Besides the main clinic area in Building 43, clinics are also conducted in Buildings 5 and 6 and at Fort Snelling. One solution would be to install a manufactured building probably east of Building 43 as a temporary facility. This would be a relatively expensive solution. Another solution would be to maintain the status quo until new clinic facilities could be constructed. The only problem then remaining would be the replacement of Buildings 5 and 6 during the construction phase of Concepts B and C. If temporary locations cannot be made available, the construction program could be arranged so that the new clinic area would be completed and occupied before construction began in the area of Buildings 5 and 6.

The major amount of renovating, which may be necessary in Building 43, also presents a phasing problem. To accomplish spaces and to make the necessary changes in mechanical systems may require vacating at least one nursing unit at a time. An alternative phasing step would be to continue the use of Building 1 after the initial new construction step is completed and occupied until the renovation of Building 43 could be completed.

Phasing problems are a major concern in the overall plan. The problems can be solved but often at the expense of a longer construction time or at considerable inconvenience to patients and staff.

Nursing Unit Configuration

The initial space program, Trial 4 of the program based on VA criteria, included nursing units of various sizes ranging from 30 to 46 beds plus the two 60-bed nursing home units. Medical nursing units included 35, 36, and 39 bed units; surgical units included 40, 41, and 46 bed units; specialty units included neurology at 38, orthopedic at 30, neurosurgery at 30, psychiatric and chemical dependence of 30, 35, 17, and 18 and intermediate and rehabilitation of 30 beds each. Space allocations varied significantly for these nursing units.

Several attempts were made to standardize these nursing units to develop a consistant size of units which would be arranged in vertical towers. Consultation with the VACO planning staff indicated a VA preference for 40-bed units as the most economical though this was questioned somewhat due to a change in VA staffing allowances. Consultation with the station staff indicated several groupings pertinent to medical education staffing and to nursing staffing namely team nursing and primary nursing staffing.

One of the first problems was the appropriate size of nursing units which were to remain in Building 43. The existing nursing units vary in size but frequently are as large as 44-45 beds. However, each existing unit includes one or more 16-bed wards and relatively few private rooms. The existing units contain little of the educational space programmed for the new nursing units. A room-by-room evaluation suggested that to comply with the programmed proportion of 1, 2 and 4 bed rooms, these nursing units would have to be reduced to approximately 30 to 33 beds and even then programmed educational space would have to be located in adjacent space rather than within the existing units. Accordingly, it was decided to use two units of this size per floor. The remaining existing unit on each floor would be used for support and educational space and for other appropriate uses such as medical or surgical service offices or special labs.

Concerning nursing units to be located in new construction, it should first be noted that certain nursing units or services should be autonomous and not shared or incorporated with other units. These include the intensive care units, psychiatry, chemical dependence, intermediate medicine and rehabilitation. Such exclusive assignment would also be desirable but perhaps not essential for orthopedics, urology and neurosurgery. After subtracting for these specialized nursing units, the balance of beds to be developed were considered as to most appropriate size.

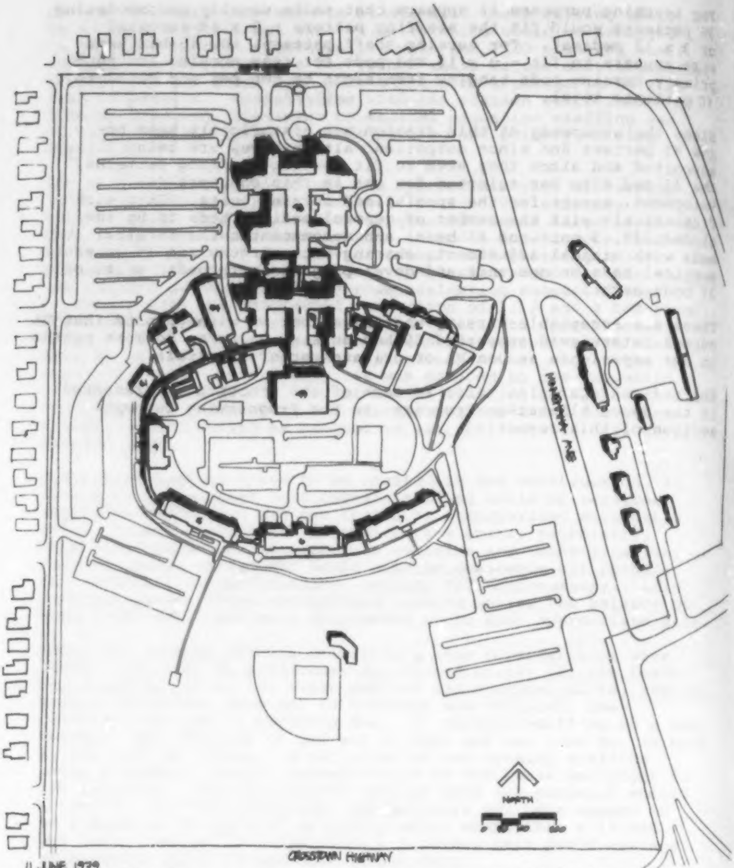
Among the primary factors influencing this consideration were three: (1) the VA preference for 40-bed units; (2) the teaching organization on the basic medical and surgical units, namely; medical,1 resident team per 12 patients and surgical, one resident team per 18 patients and; (3) nursing staffing on a pod concept, one team per 15 bed pod on days and one team per 30 beds or two pods on nights. A variation of the nursing staffing using a primary nursing concept would be one nurse per eight to ten patients. The distinction between beds and patients should be noted. Patients obviously are patients but beds appear to be planned at 85 percent occupancy which means that a 15-bed pod would average 12.75 patients - a 45-bed unit would average 38 patients and a 40-bed unit 34 patients.

For teaching purposes it appears that units usually accommodating 36 patients would fit the staffing pattern - 2 x 18 surgical or 3 x 12 medical. For nursing staff patterns the 45-bed unit size appears to fit - 3 x 15 bed pods for team nursing and four primary nursing pods ranging from eight to ten per pod or 32 to 40 patients total.

Since the occupancy at this station has historically been below 85 percent and since outpatient alternatives are being supported and since they seem to fit nursing staffing patterns, the 45-bed size was selected for use in this concepts development, except for the specialized nursing units. This size fits exactly with the number of general medical beds to be included 225, 5 units of 45 beds, and accommodates the surgical beds with minimal adjustment, sharing neurosurgery and 15 general surgical beds on one unit and developing two orthopedic units of 37 beds each.

These are acceptable nursing unit sizes but we wish to note that VA nurses interviewed supported 30 bed nursing units as do most nurses in our experience in non VA or private sector hospitals.

The bed configuration used in each of the concepts is presented in the Space Allocation Programs in the Programming Concepts section of this report.


MINNEHAHA AVE
NORTH
0 50 100 200
CROSSTOWN HIGHWAY

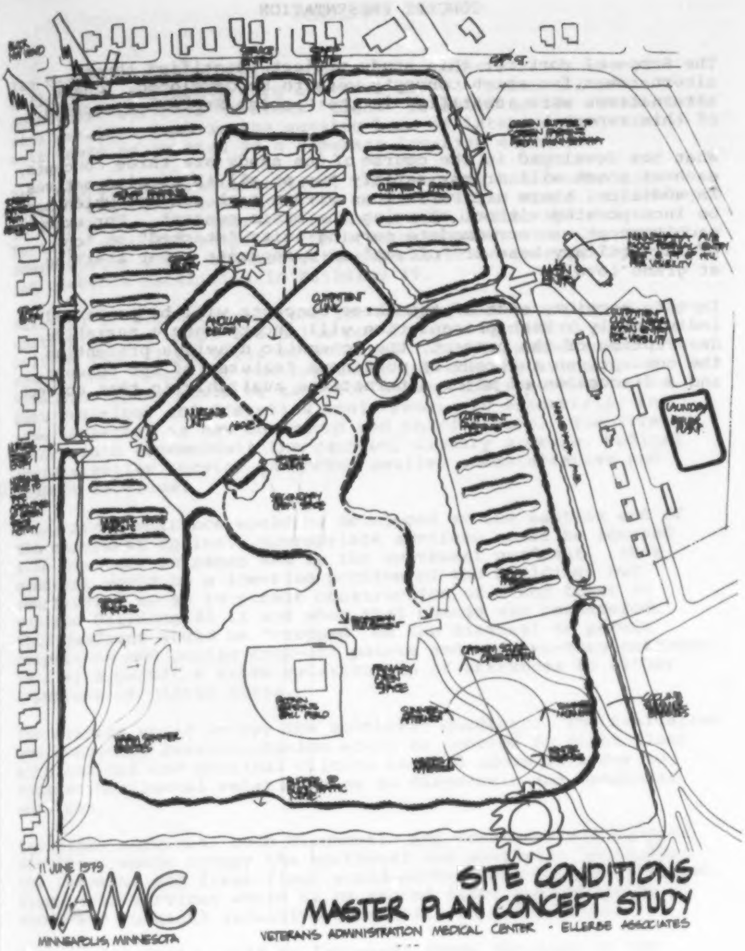
11 JUNE 1979

VAMC

MINNEAPOLIS, MINNESOTA

EXISTING SITE
MASTER PLAN CONCEPT STUDY

VETERANS ADMINISTRATION MEDICAL CENTER - ELLERBE ASSOCIATES


STAFF PARKING
OUTPATIENT PARKING
MAIN ENTRY
OUTPATIENT CLINIC
ANCILLARY BELOW
NURSING UNIT
SECONDARY OPEN SPACE
PRIMARY OPEN SPACE
LAUNDRY BOILER PLANT
11 JUNE 1979
VAMC
MINNEAPOLIS, MINNESOTA
SITE CONDITIONS
MASTER PLAN CONCEPT STUDY
VETERANS ADMINISTRATION MEDICAL CENTER - ELLERBE ASSOCIATES

CONCEPT PRESENTATION

The Scope of Work for this study project identified three alternatives for which concepts were to be developed. These alternatives were identified in the Problem Statement section of this report.

What has developed in the course of the study are three concepts, each of which will or may satisfy two or all three alternatives. In addition, there are variations within each concept which may be incorporated without changing the basic concept. For example, each concept can accommodate nursing units "stacked" on top of an ancillary base or "offset" in a separate tower starting at grade level.

In this section, each of the three concepts will be presented individually. Each presentation will incorporate a narrative description of the concept, the schematic drawings presenting the concept, an analysis of pertinent features of the concept, and a discussion of major alternatives available in that concept.

CONCEPT A

The basic premise of this concept is to make maximum use of Building 43 for acute care services and to locate all new acute care services in areas "tight" to Building 43. Less acute care services such as the nursing home or intermediate care unit could be located in a separate low-rise element.

For purposes of identification, this concept has become known as the "quadrant" concept. The total building would be developed in four quadrants separated by major circulation splines. Building 43 would comprise the northeast quadrant. The north/south spline would connect with the radiation therapy center and research facilities in Building 49.

Building 43 would be utilized for Medical and Neurology nursing units with two 32-33 bed units per floor. The third existing unit on each floor would be utilized for programmed support/educational space for the remaining two nursing units. Remaining space would be used for subspecialty service areas. Both Radiology and Dietetics would remain in essentially the same locations as now on second and third floors. The first floor would accommodate the canteen, dietary storage, medical administrative service and other smaller administrative and support services.

A new front entrance would be developed at the eastern end of the east/west spline. Appropriate services would be located with this new entrance and in the southeast quadrant. This quadrant would be a low-rise portion of the building, but constructed so as to permit construction of a bed tower to replace Building 43 if and when that change was considered. This quadrant would be "cropped" on the diagonal to permit outpatient and public drop-off points and a drive-thru entrance. This will permit a close relationship of entrances to either inpatient or clinic areas.

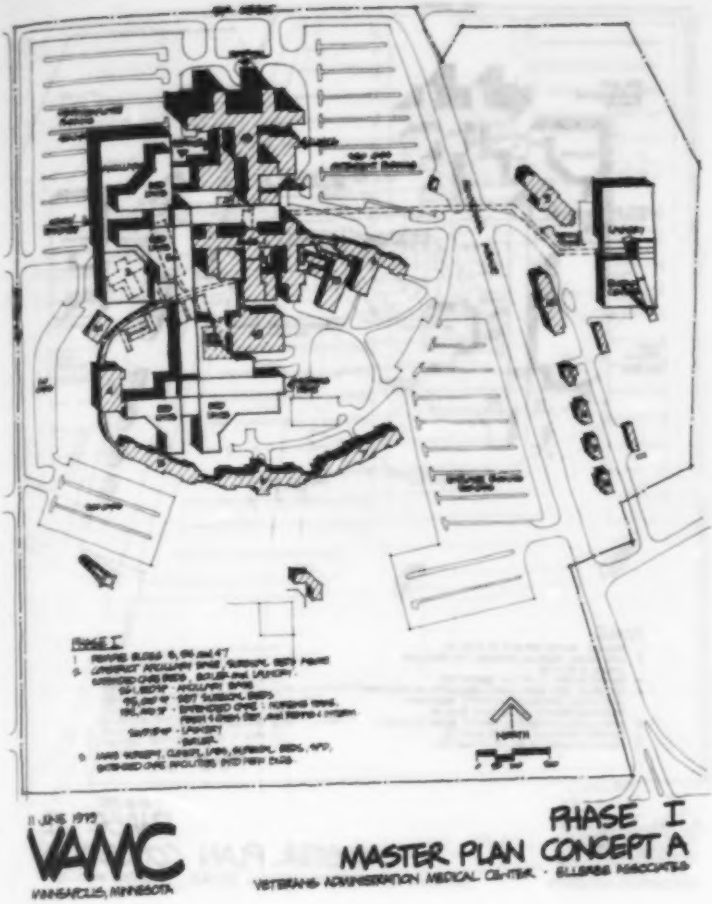
The clinics would occupy the southeast quadrant. The Evaluation and Emergency Service clinics would be located on first floor with medical and surgical clinics located above in order to achieve horizontal relationships to diagnostic and treatment services.

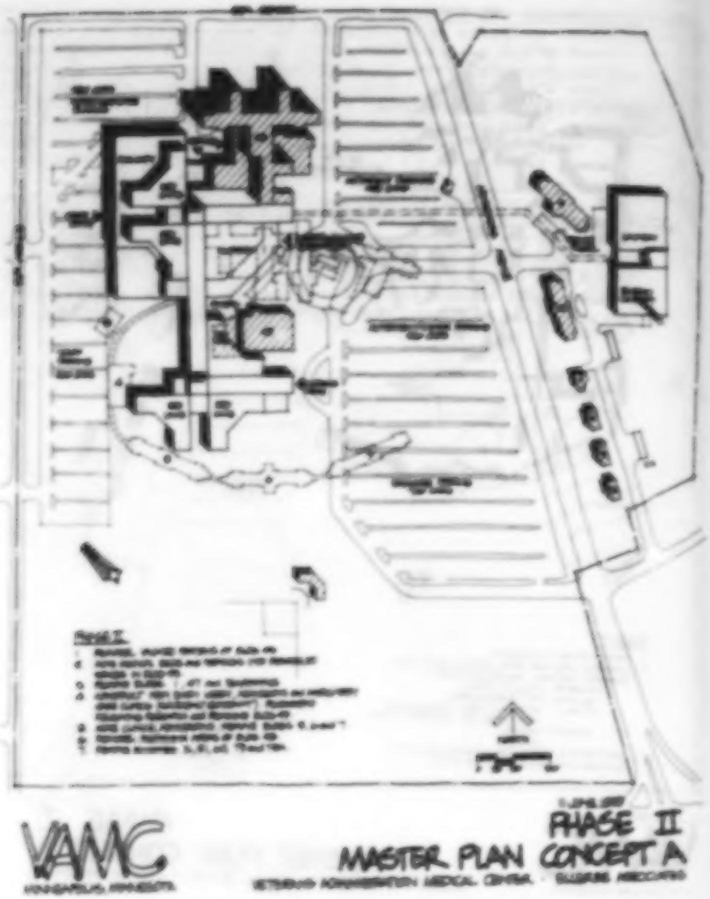
Ancillary services, both Diagnostic and Treatment and Support Services, would occupy the northwest and southwest quadrants. The basement and first floor would accommodate Support Services. Diagnostic services would be on second floor and operating rooms and surgical intensive care units on third floor.

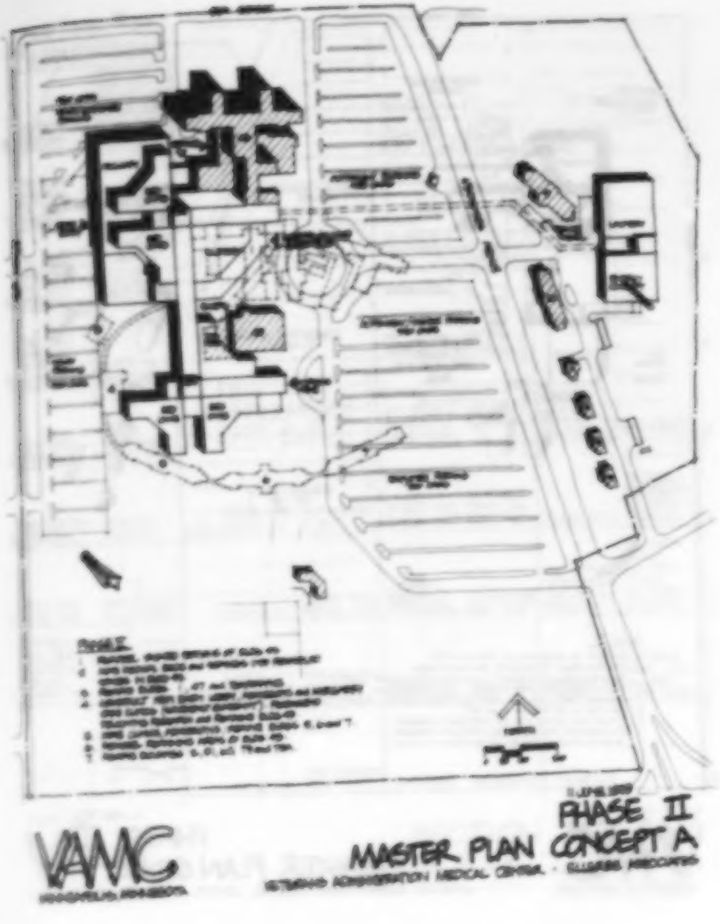
New nursing units would be "stacked" above the base in the northwest and southwest quadrants. Generally, the nursing units would be grouped as two 45-bed units per floor.

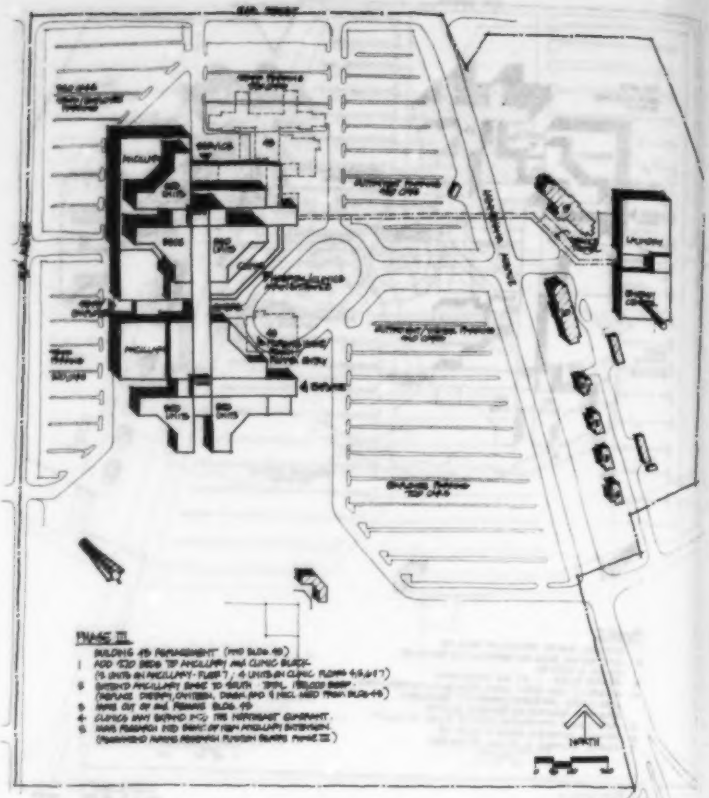
Vertical circulation would be developed at the junction of the splines and quadrants. In addition, the existing vertical circulation in Building 43 would continue to serve that building. Access to the Building 43 vertical core could be achieved near the new front entrance. Building 43 would be connected to new construction at three levels - first, second and third. Differing floor-to-floor heights would require a ramp down on first floor and a ramp up on third floor. The second floor would be level.

As presented in Concept A drawings, the nursing home, psychiatric service and intermediate and rehabilitation services would be located in a three-level building located south of the southwest quadrant and connected by an extension of the north/south spline. This location would permit the low rise location desired for these services and takes advantage of the park-like setting for these services.


PHASE I
NORTH
11 JUNE 1979
VAMC
MINNEAPOLIS, MINNESOTA
PHASE I
MASTER PLAN CONCEPT A
VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES


PHASE II
MASTER PLAN CONCEPT A
VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES
VAMC
MINNEAPOLIS, MINNESOTA


PHASE II
MASTER PLAN CONCEPT A
VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES
VAMC
MINNEAPOLIS, MINNESOTA
NORTH


SERVICE
ANCILLARY
BED UNITS
ANCILLARY
BED UNITS
BED UNITS
LAUNDRY
PHASE III
BUILDING 49 REPLACEMENT (AND BLDG 48)
1 ADD 520 BEDS TO ANCILLARY AND CLINIC BLOCK
2 EXTEND ANCILLARY SPACE TO SOUTH
3 MOVE OUT OF AND REMOVE BLDG 49
4 CLINICS MAY EXPAND INTO THE NORTHEAST QUADRANT.
5 MOVE RESEARCH INTO SPACE OF NEW ANCILLARY EXTENSION.
NORTH

11 JUNE 1979

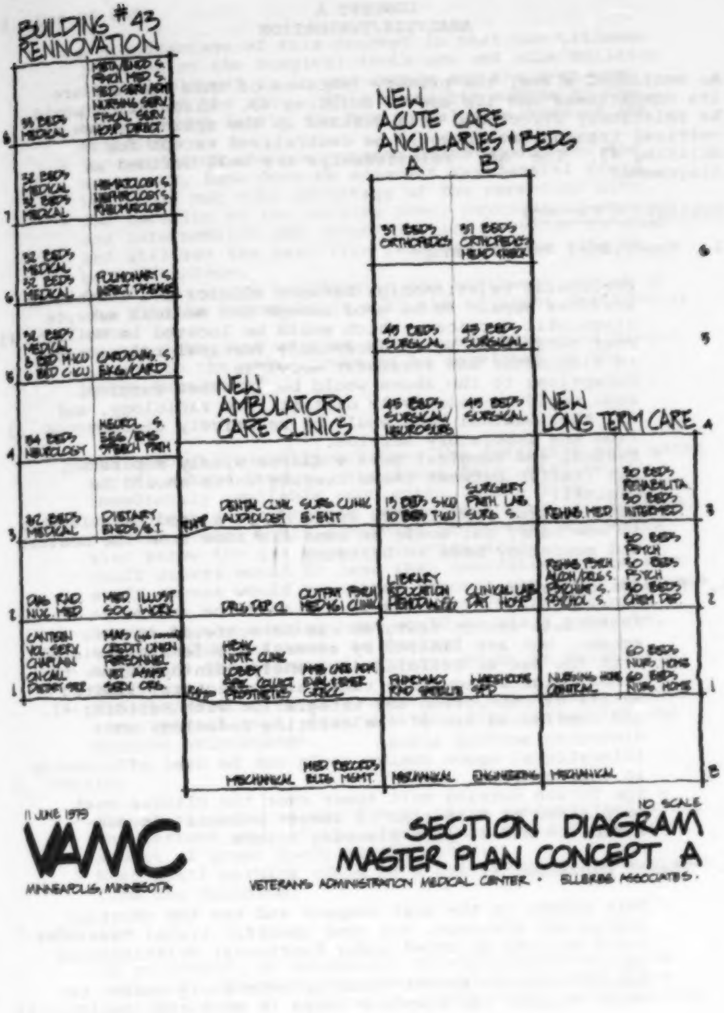
PHASE III

MASTER PLAN CONCEPT A

VAMC

MINNEAPOLIS, MINNESOTA

VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES


BUILDING #43
RENNOVATION
META/ENDO S.
PHYS MED S.
MED SERV ADM
NURSING SERV.
FISCAL SERV.
HOSP DIRECT.
55 BEDS
MEDICAL
8
32 BEDS
MEDICAL
32 BEDS
MEDICAL
HEMATOLOGY S.
NEPHROLOGY S.
RHEUMATOLOGY
7
32 BEDS
MEDICAL
32 BEDS
MEDICAL
PULMONARY S.
INFECT. DISEASE
6
32 BEDS
MEDICAL
6 BED MICU
6 BED CICU
CARDIOVAS. S.
EKG/CARD
5
64 BEDS
NEUROLOGY
NEUROL S.
EEG/EMG
SPEECH PATH
4
32 BEDS
MEDICAL
DIETARY
ENDOS/G.I.
3
DIAG RAD
NUC MED
MED ILLUST
SOC. WORK
2
CANTEEN
VOL. SERV.
CHAPLAIN
ON CALL
DIRECT SUPP.
MAS
CREDIT UNION
PERSONNEL
VET ADMIT
SERV. ORG.
1
NEW
ACUTE CARE
ANCILLARIES & BEDS
A
B
51 BEDS
ORTHOPEDICS
51 BEDS
ORTHOPEDICS
HEAD INJURY
6
45 BEDS
SURGICAL
45 BEDS
SURGICAL
5
NEW
AMBULATORY
CARE CLINICS
45 BEDS
SURGICAL/
NEUROSURG
45 BEDS
SURGICAL
NEW
LONG TERM CARE
4
RAMP
DENTAL CLINIC
AUDIOLOGY
SURG CLINIC
E-ENT
15 BEDS SICU
10 BEDS TICU
SURGERY
PATH. LAB
SURG S.
REHAB. MED
30 BEDS
REHABILITA
30 BEDS
INTERMED
3
DRUG DEP CL
OUTPAT PSYCH
MED/GI CLINIC
LIBRARY
EDUCATION
PERIODICALS
CLINICAL LAB
DAY HOSP
REHAB PSYCH
AUDIO/DRUGS
PSYCHIAT S.
PSYCHOL S.
30 BEDS
PSYCH
30 BEDS
PSYCH
30 BEDS
CHEM DEP
2
RAMP
MEAL
NUTR CLINIC
LOBBY
SPEC. COLLECT.
PROSTHETICS
AMB CARE ADM
EVAL & EMER
GRILL
PHARMACY
RAD SATELLITE
WAREHOUSE
SPD
NURSING HOME
CENTRAL
60 BEDS
NURS HOME
60 BEDS
NURS HOME
1
MECHANICAL
MED RECORDS
BLDG MGMT.
MECHANICAL
ENGINEERING
MECHANICAL
B
NO SCALE

11 JUNE 1979

VAMC

MINNEAPOLIS, MINNESOTA

SECTION DIAGRAM
MASTER PLAN CONCEPT A

VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES ·

CONCEPT A
ANALYSIS/EVALUATION

As mentioned above, the primary features of this concept are its compactness and its use of Building 43. Circulation would be relatively direct and well defined in the spline system and vertical transportation would be centralized except for Building 43. The "ABC" relationships are well defined as diagrammed.

Evaluation Factors

1. Functional Relationships

   - Horizontal relationships between clinics and diagnostic services appear to be good except for medical service diagnostic services, which would be located in Building 43.
   - Most beds would be in acceptable vertical relationship to diagnostic and treatment services.
   - Exceptions to the above would be (1) that surgical beds would be relatively distant from radiology, and (2) that medical beds would be relatively distant from the laboratory service.
   - Medical and surgical beds would be widely separated, but traffic between these nursing units should be minimal.
   - Most service departments would be in a good relationship to new beds, but would be some distance from the medical and neurology beds in Building 43.

2. Freedom of Design

   - Acceptable design features can be achieved in this scheme, but are limited by several problems associated with the use of Building 43, namely, minimal floor-to-floor heights requiring ramps as connectors, limited points of connection and integration with Building 43, and continuing use of the existing radiology and dietetics service areas.
   - Interstitial space design could not be used efficiently in this concept.
   - The future nursing unit tower over the clinics must be planned at this time to locate columns and substructure and to plan plumbing risers.

3. Travel Distance

   - This scheme is the most compact and has the shortest end-to-end distance, but some specific travel distances would be long as noted under Functional Relationships above.
   - Support service travel would be relatively short, but could require two elevator trips in servicing Building 43.

4. Use of Site

   - A disadvantage of this concept is that the ultimate location of the hospital (both now and when Building 43 is replaced) is in one corner and the narrowest portion of the site. This restricts access to the building and limits the horizontal extension of the building.
   - The view from the new nursing units would, for the most part, look down on adjacent residential areas, but would not take advantage of the park-like site.
   - The location of the nursing home, psychiatric service and intermediate and rehabilitation services is good and utilizes the park-like features of the site to good advantage.
   - Locating a large building in the northwest corner of the site is incompatible with the adjacent residential area.
   - Clinic lobby and waiting areas would have good visual access to the green areas to be developed at the entry turnaround.

5. Access

   - The concept generally achieves the desirable site entry off Minnehaha Avenue. The front entry will be immediately available upon entry to the site. Public and outpatient entrances can be separated, if desired.
   - Service access would remain as at present and would also serve the new Support Service areas.
   - Staff access would be less than desirable, since most staff access would be either through the front entrance or at the southern end of the north/south spline.
   - Access to the nursing home would be via a separate identifiable entrance, as desired.
   - Access to the emergency entrance might be relatively obscure.
   - Though possible, this concept does not readily accept a peripheral road, desirable for fire protection and routine maintenance.

6. Parking

   - Almost all parking would have to be concentrated along the eastern edge of the site. This would limit the amount of green space at the entry.
   - Most staff parking would be a relatively great distance from the building.

7. Phasing

   - As presented, an acceptable phasing sequence can be achieved. However, any scheme which utilizes space near Building 43 results in a more complicated phasing plan.

- This scheme would require at least three relatively long phasing steps: (1) construction in the northwest/southwest quadrants, (2) renovation of Building 43, and (3) construction in the southeast quadrant. This scheme would place clinic construction in the last phase of development.
- This scheme would also require a "temporary" east/west spline between the existing Buildings 43 and 1, and a different connecting corridor to serve Buildings 4, 5 and 6 during the initial construction phase.

CONCEPT A
ALTERNATIVES

In this concept, as in each of the concepts, there are many variations possible for the internal location of services. These will be determined more accurately during the design development phase of planning.

One major alternative in this concept would be to move the Ancillary Services to the north and to locate beds in a grade-up tower in the southwest quadrant. Better horizontal relationships could be developed, but clinic construction would be in the last phase of development. This alternative would permit bringing the psychiatric and intermediate and rehabilitative services into the lower levels of the acute care bed tower.

A second alternative would be to move the Ancillary Services to the north and develop the clinics in the southwest quadrant. Only the lobby and administrative services would be located in the southeast quadrant. This would permit an early construction of the clinics space, but would place them at a greater distance from the front entry. A separate clinic entrance located near the south spline would solve this problem.

CONCEPT B

The basic premise of this concept is to locate the ultimate site of the new building to the south of Building 49, maintaining a connector to Building 43. Consultation with the HCFS and station administrative staff suggested that psychiatry, both in and outpatient, be concentrated in Building 43 along with selected Support Services. Acute care services would be located in the new construction south of Building 49. The design of the new construction would locate clinics and diagnostic services close to Building 49 and, therefore, reasonably close to Building 43. The distance would be approximately equal to the present distance from Nuclear Medicine to the lobby of Building 43.

This concept negates the problems of building in close proximity to Building 43 (floor-to-floor heights, limited connectors, etc.) reduces the phasing problems, but more importantly places the ultimate location of the hospital facility in the center of the site.

A new front entrance would be developed at the easterly end of the Ancillary/Clinic block with access from Minnehaha Avenue. Appropriate administrative services and the clinic/ambulatory care services would be developed in the easterly portion of the Ancillary/Clinic block with good access to the new entrance. Diagnostic and Treatment services and Support Services would occupy the western portion of this block with Support Services on the lower and perhaps first floor and Diagnostic and Treatment Services on the upper floors. Though the number of floors in this block is optional, it is likely that four floors above grade would be required, as presented in the scheme drawings.

Nursing units are presented as in two low-rise towers each with two 45-bed units or 180 beds per floor. These towers would each be served by a vertical core and would be located to the south of the Ancillary/Clinic block. This location will facilitate horizontal relationships between the beds and diagnostic services including medical staff offices and, depending upon internal location of the various clinic areas, may permit these horizontal relationships to extend to clinic areas, i.e. on one level - Medical beds - pulmonary and cardiac laboratories - Medical Service offices - Medical clinics. It should be noted that while the total building is large, the distances most patients and staff would travel would be relatively short because of the horizontal relationship of related services.

As presented in this concept, the nursing home would be located on the ground floor of one of the nursing unit towers. Since these units are larger than the acute care units, they would extend beyond the acute care units above and would, therefore, present the identifiable image desired for this service. At the same time, the nursing home units would be connected to the regular hospital circulation routes, thereby facilitating the servicing of these units.

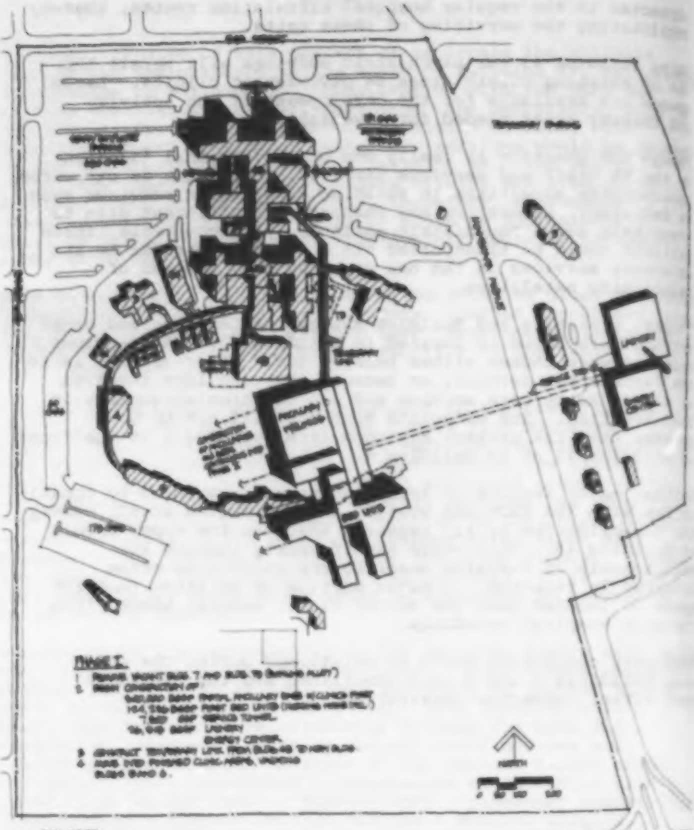
Using Building 43 for psychiatric services will permit the use of existing clinic areas as psychiatric clinics. Large spaces are available for the development of the activity and therapy areas needed for psychiatry.

Though the question is really one of professional judgement by the VA staff and services involved, the scheme as presented incorporates satellites in Building 43 of basic services such as Radiology, Laboratory and Pharmacy of sufficient size to adequately serve Psychiatric patients. If acceptable, these patients could be transported via a direct connector to the necessary services in the new construction, instead of maintaining satellites.

Supply, Dietetics and Building Management Services and other services are shown as located in Building 43. The services selected were chosen either because their major service is to the Psychiatric Service, or because they are less involved in direct acute care service and can function adequately in this location. The effective distance will not be much greater than the present distance from Building 2 to the front of Building 43 or to Building 4.

Another major feature of this concept was suggested by consultation with the VACO and station administrative staff, namely the consolidation of all research space on the upper levels of Building 43. This would significantly improve the relationship of research space to the clinicians often involved in research. A major portion of existing research space is located near the Boiler Plant, several blocks from the main hospital buildings.

Temporary connectors would be maintained during the phase when Buildings 1 and 2 were demolished and the permanent, more direct connector constructed.


PHASE I.
LAUNDRY
ENERGY CENTER
NORTH

11 JUNE 1979

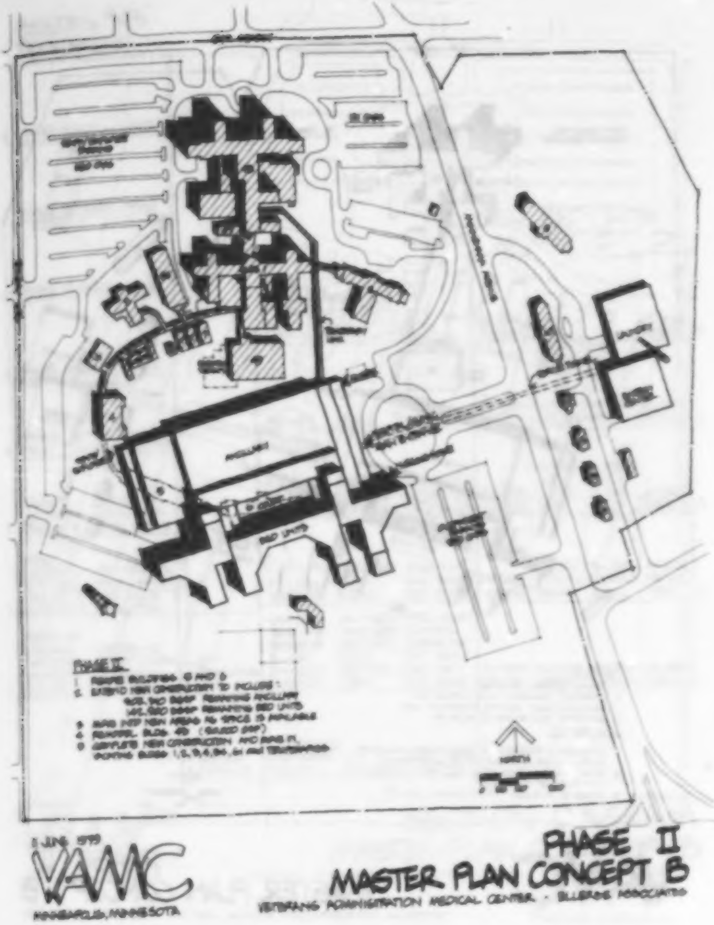
VAMC

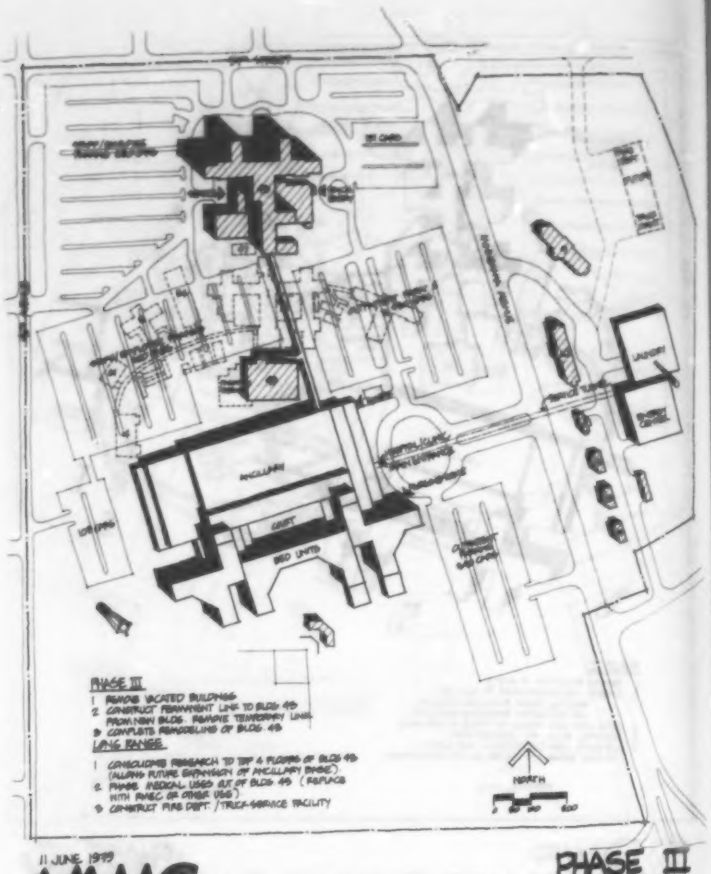
MINNEAPOLIS, MINNESOTA

PHASE I

MASTER PLAN CONCEPT B

VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES


PHASE II
NORTH
1 JUNE 1979
VAMC
MINNEAPOLIS, MINNESOTA
PHASE II
MASTER PLAN CONCEPT B
VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES


ANCILLARY
COURT
BED UNITS
LAUNDRY
ENERGY CENTER
NORTH
0
50
100
200

PHASE III

1 REMOVE VACATED BUILDINGS
2 CONSTRUCT PERMANENT LINK TO BLDG 43 FROM NEW BLDG. REMOVE TEMPORARY LINK
3 COMPLETE REMODELING OF BLDG. 43

LONG RANGE

1 CONSOLIDATE RESEARCH TO TOP 4 FLOORS OF BLDG 43 (ALLOWS FUTURE EXPANSION OF ANCILLARY BASE)
2 PHASE MEDICAL USES OUT OF BLDG 43 (REPLACE WITH RMEC OR OTHER USE)
3 CONSTRUCT FIRE DEPT. / TRUCK-SERVICE FACILITY

11 JUNE 1979

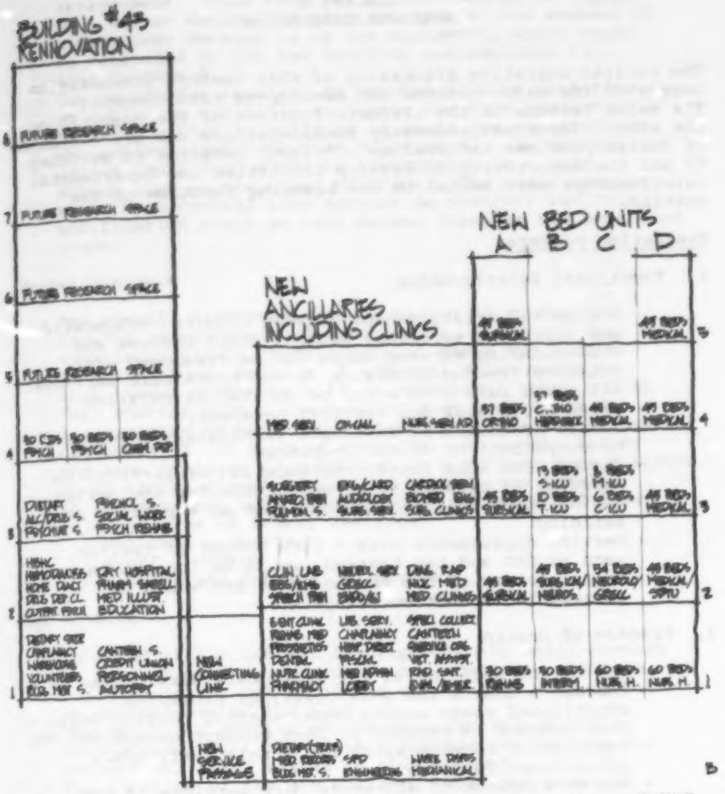
VAMC

MINNEAPOLIS, MINNESOTA

PHASE III

MASTER PLAN CONCEPT B

VETERANS ADMINISTRATION MEDICAL CENTER - ELLERBE ASSOCIATES


BUILDING #43
RENNOVATION
8 FUTURE RESEARCH SPACE
7 FUTURE RESEARCH SPACE
6 FUTURE RESEARCH SPACE
5 FUTURE RESEARCH SPACE
4 30 BEDS PSYCH
30 BEDS PSYCH
30 BEDS CHEM DEP.
3 DIETARY
ALC/DRUG S.
PSYCHIAT S.
PSYCHOL S.
SOCIAL WORK
PSYCH REHAB
2 HEMC
HEMODIALYSIS
HOME DIAL
DRUG DEP CL.
OUTPAT PSYCH
DAY HOSPITAL
PHARM SATELL
MED ILLUST.
EDUCATION
1 DIETARY SER
CHAPLAINCY
WAREHOUSE
VOLUNTEERS
BLDG MGT S.
CANTEEN S.
CREDIT UNION
PERSONNEL
AUTOPSY
NEW CONNECTING LINK
NEW SERVICE PASSAGE
NEW ANCILLARIES INCLUDING CLINICS
MED SERV.
ON-CALL
NURS SERV AD.
SURGERY
ANESTH. SERV
PULMON. S.
EKG/CARD
AUDIOLOGY
SURG. SERV.
CARDIOL SERV
BIOMED ENG
SURG. CLINICS
CLIN. LAB
EEG/EMG
SPEECH PATH
NEUROL. SERV.
GRECC
ENDO/GI
DIAG. RAD
NUC. MED
MED CLINICS
EENT CLINIC
REHAB MED
PROSTHETICS
DENTAL
NUTR. CLINIC
PHARMACY
LAB SERV.
CHAPLAINCY
HOSP. DIRECT.
FISCAL
MED ADMIN.
LOBBY
SPEC. COLLECT.
CANTEEN
SERVICE ORG.
VET. ASSIST.
RAD. SAT.
EVAL./ADMIT
DIETARY (TRAY)
MED RECORDS
BLDG MGT. S.
SPD
ENGINEERING
WASTE DISPOS.
MECHANICAL
NEW BED UNITS
A
B
C
D
47 BEDS SURGICAL
45 BEDS MEDICAL
5
37 BEDS ORTHO
37 BEDS C.-THO HEMODIAL
45 BEDS MEDICAL
45 BEDS MEDICAL
4
45 BEDS SURGICAL
13 BEDS S-ICU
10 BEDS T-ICU
8 BEDS M-ICU
6 BEDS C-ICU
45 BEDS MEDICAL
3
45 BEDS SURGICAL
45 BEDS SURG ICU/NEUROS.
54 BEDS NEUROLOGY/GRECC
45 BEDS MEDICAL/SPTU
2
30 BEDS REHAB
30 BEDS INTERM.
60 BEDS NURS. H.
60 BEDS NURS. H.
1
B

11 JUNE 1979

VAMC

MINNEAPOLIS, MINNESOTA

NO SCALE

SECTION DIAGRAM
MASTER PLAN CONCEPT B

VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES ·

CONCEPT B
ANALYSIS/EVALUATION

The earlier narrative discussion of this concept presentation suggested the major reasons for developing this concept. The major feature is the ultimate location of the hospital on the site. Important secondary considerations are the avoidance of design problems involved by a "tight" location to Building 43 and the opportunity to develop facilities and departmental relationships more suited to the teaching function of the station.

Evaluation Factors

1. Functional Relationships

   - Horizontal relationships between clinics, diagnostic and treatment services, medical staff offices and corresponding nursing units can be developed with relative freedom of design in the acute care services.
   - All acute care beds would be located in relatively close horizontal and vertical proximity.
   - Clinic areas can be developed immediately adjacent to outpatient or clinic entrances.
   - Though less than ideal, the location of services in Building 43 appears to be acceptable for the period during which Building 43 continues as a patient care building.
   - Service departments with a high volume of traffic, such as SPD and the Canteen, would be located in the major portion of the new building and would be accessible to both buildings.

2. Freedom of Design

   - The use of Building 43 for acute care services as in Concept A limits the possibility of providing educational space within each existing nursing unit. This problem is negated in this concept except for the Psychiatric Service which has a relatively small educational function.
   - The development of all acute care services in new construction permits an utmost freedom of design in developing the new facility.
   - Mechanical systems and concepts such as interstitial space may be incorporated without the constraint of adapting to Building 43.
   - Concept A contemplates leaving Radiology and Dietetics in existing space because of the expense of relocating these services. The Radiology Service facility in Building 43 is essentially a linear design following the envelope of the nursing units located above the department. Contemporary Radiology design intended to improve the efficiency of operation utilizes groupings of procedure rooms in a peripheral/core

arrangement. This requires a block design as opposed to a linear design. A major portion of the expense of a Radiology Service is in the equipment, which could be relocated to the new facility contemplated in this Concept B.

- One compromise required in Concept B is in Dietetics. An option is available to locate the food production facility either in Building 43 or in new construction. The scheme locates this in Building 43. In either option, bulk food would be transported to a tray makeup line in the other building. The basic service would be a central tray service as desired; the only modification would be tray makeup lines in two separated areas.

3. Travel Distance

- The overall distances (from Building 43 to the new nursing units) obviously are longer, but there will be relatively little traffic between these two points. As noted above, because of internal relationships, most travel distances will be relatively short and in fact shorter than corresponding ones in Concept A.
- A compromise is made compared to Concept A in the travel distances of the Support Services. At least, during the time Building 43 continues as a patient care building, these travel distances will be longer than ideal.
- It appears that this concept would permit the following priorities as to travel distance.
  - Patients - shortest
  - Staff - medium
  - Service and material - longest

4. Use of Site

- As noted in the concept description, the basic premise or purpose of this concept is to locate the ultimate building in the center of the site. This will permit an optimal use of the site.
- The park-like setting of the site can and should be maintained. Full use of this setting can be made for patient and staff vistas in this concept.
- The location of the new building would not visually impinge upon adjacent residential areas.
- The building may be sited to take advantage of solar energy.
- Rotation of the complex in a southeasterly direction allows response to both optimum solar orientation and to Minnehaha Avenue alignment. Minnehaha Avenue is the main entry road and also breaks from the basic north-south city grid. The building becomes more special in the process.
- The location of Building 49 forces the new construction further south than desired. This consumes more open space and places the complex close to the Crosstown Highway.

5. Access

   - As in Concept A, Concept B achieves the desired entry off Minnehaha Avenue with the front entry clearly and distinctly apparent on entering.
   - Entrances for various types of traffic - patients, public, staff, service - can be developed almost as desired. There would be relatively few limitations.
   - Access to the nursing home could be through a separate entrance, if desired.
   - A full or partial peripheral road can readily be incorporated in the site design.
   - The most southerly location of the new building may force the entry from Minnehaha Avenue further south. This entry is best at its present location.

6. Parking

   - The central location of the building will permit locating parking areas almost anywhere around the building. Parking lots can be developed in relation to the entrances desired for use, i.e., public to the front entry, staff to a staff entrance.
   - Distances from parking lots to entrances can be kept to a minimum.
   - The smaller outpatient parking lots may be developed with more "green" space while staff and service parking may be hidden from the main entry area.

7. Phasing

   - Phasing problems are relatively minor, requiring only that either a temporary location be made for the clinic services in Buildings 5 and 6, or that the first stage of construction provide for the completion of space for these clinics before the buildings are demolished and construction begun in that area of the site.
   - The only other significant phasing problem would be maintaining a temporary connector to Building 43 during the time Building 1 is demolished and a permanent connector constructed.

CONCEPT B
ALTERNATIVES

The freedom of design of the acute care services in this concept extend to the alternatives which may be considered. There are many such alternatives:

1 Nursing units could be "stacked" above the Ancillary/Clinic block, rather than "offset" as presented.

2. Various arrangement of 1-2 or 3 level clinics are possible.

3. The orientation of the new construction is along an east/west spline separating the Ancillary/Clinic block and the nursing unit tower. A north/south spline would connect with Building 43. An alternative can be considered, incorporating a north/south spline with the Ancillary/Clinic block to the west and the nursing unit towers to the east of that spline.

4. Support Services could be located in a service building connector in the general area of the present Building 1. This would place them more centrally to both Building 43 and the new building, but would compromise their location in the ultimate design. This alternative would depend upon the disposition of Building 49 and would delay construction of this service building until Building 1 is demolished.

CONCEPT C

The basic premise of this concept is to totally replace all existing facilities providing all of the programmed space in essentially one construction project. The similarity to Concept B is immediately apparent. The main variation is that the size of the building is increased in order to allow for the spaces shown in Building 43 in Concept B.

The design features are much the same, featuring horizontal relationships between the nursing unit towers and the ancillary/clinic block and, within those major blocks, horizontal relationships between beds--diagnostic services--offices--clinics. Vertical circulation and support service relationships would be similar to Concept B.

The site is essentially level, creating no major topographic or grade level problems or design features. The design concept adapts well to the large open site available at the present location. This design concept may or may not fit an alternate site if such a move were contemplated.

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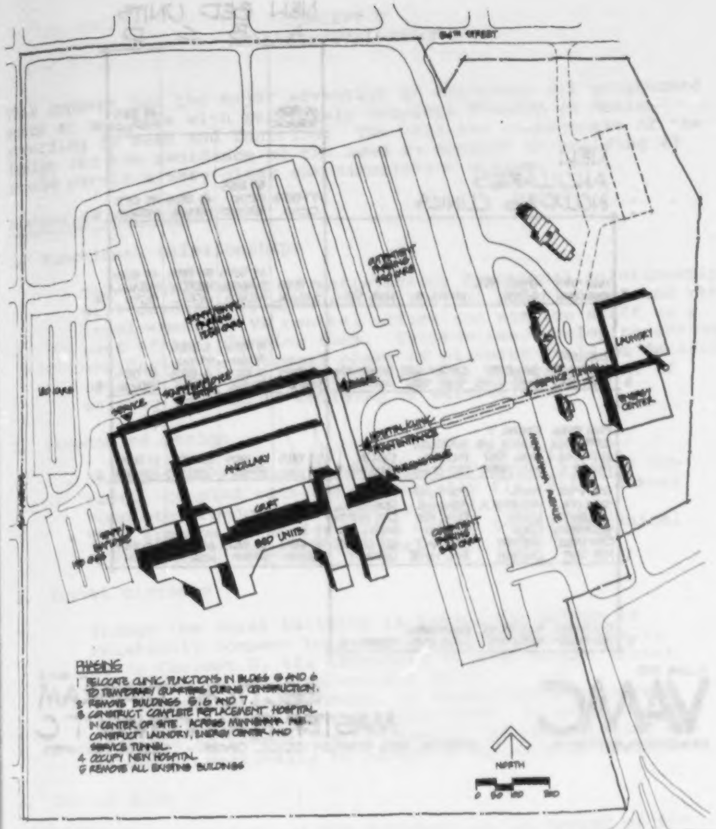
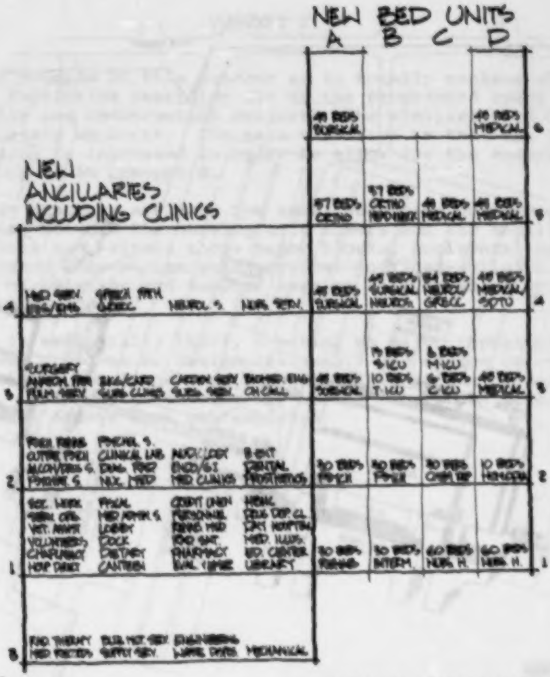

54TH STREET
LAUNDRY
ENERGY CENTER
SERVICE TUNNEL
SERVICE
ANCILLARY
COURT
BED UNITS
HOSPITAL/CLINIC MAIN ENTRANCE
MINNEHAHA AVENUE
NORTH
0 50 100 200

PHASING
1 RELOCATE CLINIC FUNCTIONS IN BLDGS 5 AND 6 TO TEMPORARY QUARTERS DURING CONSTRUCTION.
2 REMOVE BUILDINGS 5, 6 AND 7.
3 CONSTRUCT COMPLETE REPLACEMENT HOSPITAL IN CENTER OF SITE. ACROSS MINNEHAHA AVE. CONSTRUCT LAUNDRY, ENERGY CENTER AND SERVICE TUNNEL.
4 OCCUPY NEW HOSPITAL.
5 REMOVE ALL EXISTING BUILDINGS

11 JUNE 1979
VAMC
MINNEAPOLIS, MINNESOTA

COMPLETE
MASTER PLAN CONCEPT C
VETERANS ADMINISTRATION MEDICAL CENTER · ELLERBE ASSOCIATES


NEW BED UNITS
A
B
C
D
45 BEDS SURGICAL
45 BEDS MEDICAL
6
57 BEDS ORTHO
57 BEDS ORTHO NEPH/UROL
45 BEDS MEDICAL
45 BEDS MEDICAL
5
NEW ANCILLARIES INCLUDING CLINICS
4
MED SERV.
EEG/EMG
GRECC RSCH.
GRECC
NEUROL S.
NURS. SERV.
45 BEDS SURGICAL
45 BEDS SURGICAL NEUROS.
54 BEDS NEUROL/ GRECC
45 BEDS MEDICAL/ SDTU
4
3
SURGERY
ANESTH. RM
PULM. SERV.
EKG/CARD
SURG. CLINICS
CARDIOL. SERV.
SURG. SERV.
BIOMED. ENG.
ON CALL
45 BEDS SURGICAL
14 BEDS S ICU
10 BEDS T ICU
6 BEDS M ICU
6 BEDS C ICU
45 BEDS MEDICAL
3
2
PSYCH. RSRCH.
OUTPAT. PSYCH
ALCOH/DRUG S.
PSYCHIAT. S.
PSYCHOL. S.
CLINICAL LAB.
DIAG. RAD
NUC. MED
AUDIO/SPEECH
ENDO/G.I.
MED CLINICS
E-ENT
DENTAL
PROSTHETICS
30 BEDS PSYCH
30 BEDS PSYCH
30 BEDS CHEM. DEP
10 BEDS HEMODIAL
2
1
SOC. WORK
VET. ASST
VOLUNTEERS
CHAPLAINCY
HOSP DIRECT
FISCAL
MED ADMIN S.
LAUNDRY
DOCK
DIETARY
CANTEEN
CREDIT UNION
PERSONNEL
PHARMACY
MEDIA
DRUG DEP. CL.
MED. ILLUS.
ED. CENTER
LIBRARY
30 BEDS REHAB
30 BEDS INTERM.
60 BEDS NUR. H.
60 BEDS NUR. H.
1
B
RAD THERAPY
MED RECORDS
SUPPLY SERV.
ENGINEERING
MECHANICAL

11 JUNE 1979

NO SCALE

VAMC

MINNEAPOLIS, MINNESOTA

SECTION DIAGRAM
MASTER PLAN CONCEPT C

VETERANS ADMINISTRATION MEDICAL CENTER - ELLERBE ASSOCIATES

CONCEPT C
ANALYSIS/EVALUATION

This concept has the major advantage of designing all programmed space at one time with relatively complete freedom to design according to need and function. The relative compactness of the design and the avoidance of the need to connect to building 43 should permit a very clear cut circulation system.

Evaluation Factors

1. Functional Relationships

- The establishment of satisfactory functional relationships will depend only upon the ability of the planners and the involvement of VA central office and station staff as a part of the planning team. Compromises developing during the design development phase of planning could be decided upon current priorities but without the constraint of serving any remote building or service.

2. Freedom of Design

- The obvious freedom of design is apparent in this concept. Coupled with the essentially flat site, almost complete freedom of design is available.
- This freedom of design would extend to all mechanical systems and transport systems.

3. Travel Distance

- Though the total building is large, the scheme is relatively compact both horizontally and vertically. As in Concept B, the essential or high volume travel distances would be relatively short.
- If, in design development, it should become apparent that certain distances are too great, it would be possible to reduce the "footprint" of the building and extend it vertically to adjust to acceptable distances.

4. Use of Site

- This concept places the building in the center of the site, the optimal long-range location.
- This location will permit the establishment of appropriate parking lot locations and parking lot to entrance relationships.
- This concept also reduces the impact of the building on the surrounding residential areas and takes advantage of the park-like setting for the nursing units.

- As in Concept B, the location of the new building is farther south than desired in order to maintain a better site entry point and better preservation of open spaces.

5. Access

   - As in the other concepts, Concept C establishes the site entry off Minnehaha as desired and relates the patient/public entrance to that site entry.
   - Patient/public entrances can be established as desired, staff entrances can be controlled, and service entrances can be separated from other entrances and located close to service areas.

6. Parking

   - As mentioned under access, parking lots can be established in appropriate locations and, within reason, of approximate sizes needed in each lot or location.

7. Phasing

   - There are essentially no phasing problems in this concept except possibly the temporary replacement of buildings 5 and 6 clinic areas, and the disruption of existing parking lots.

CONCEPT C
ALTERNATIVES

The alternatives in Concept C are essentially the same as in Concept B, except that the service building alternative does not seem viable in this concept.

As a guide to the evaluation of the three concepts and the decision of one concept for final development of the Master Plan for the VAMC - Minneapolis, the following issues seem pertinent:

1. How important is the ultimate location of the building on the site and in relation to surrounding residential areas?

   Is the location in the northwest portion of the site acceptable?

2. How acceptable is the separation of services such as Psychiatry and selected Support Services from the acute care services during the remaining life of building 43?

3. Is the need to provide contemporary mechanical systems and floor-to-floor heights greater than the need to tie new facilities tight to building 43?

4. Can the location of parking lots to appropriate building entrances be compromised?

5. Is the continued use of building 49 important enough to force a compromise in the ultimate design solution?

6. Are the phasing requirements acceptable in the impact on day-by-day operations and on the time requirements?

7. Are the priorities of the VA Hospital System met as to:

   - initial clinic versus beds construction
   - interdepartmental relationships
   - travel distances for:
     - patients
     - staff
     - service?

8. Which is most important--cost now versus total eventual cost?

9. Is the investment in building 43 of such magnitude as to justify the planned use for this building in each of the concepts?

10. How adaptable is each concept to modification or expansion to meet future and unpredictable needs?

11. Is the impact of the teaching and specialized care requirements at this station sufficient to require most or all acute care services to be located in newly designed facilities?

12. What are the total cost and "fundability" potential of major projects at this station?

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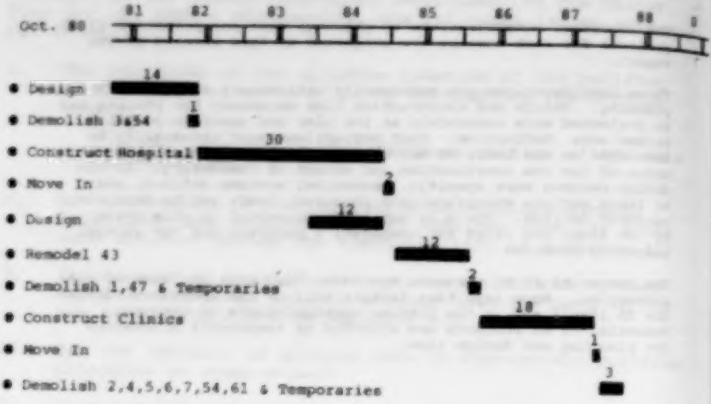
PHASING SCHEDULES - CONCEPT COSTS - FY 81 PROJECTS

The important considerations of phasing, cost and potential FY 81 projects for each concept are presented in this section of the report.

These considerations are necessarily preliminary at this stage of planning. Design and construction time necessary for phasing can be projected more accurately as the plan and specific projects become more definitive. Cost projections must necessarily be developed on the basis of departmental square footages with estimates of the new construction and extent of remodeling. As the design becomes more specific, mechanical systems defined, and at least outline specifications prepared, costs can be more accurately defined. The cost estimates presented in this phase of the study are valid for comparative purposes and for general budgeting purposes.

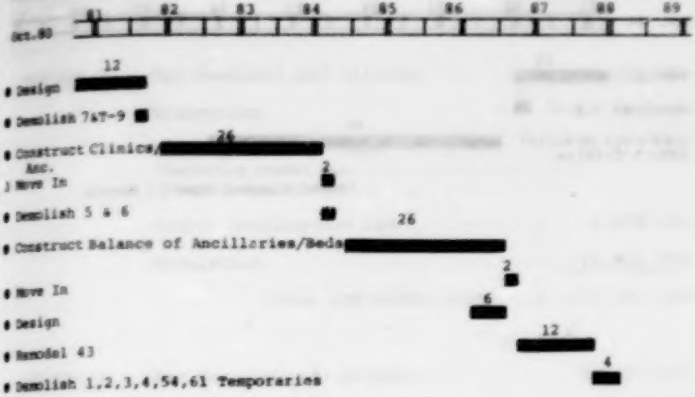
The potential FY 81 projects are identified only for general consideration. More important factors will be the decisions within the VA itself and in the funding appropriations of Congress. Potential FY 81 projects are affected by reasonable allowances for planning and design time.

Concept A **Schedule** **VAMC Minneapolis**



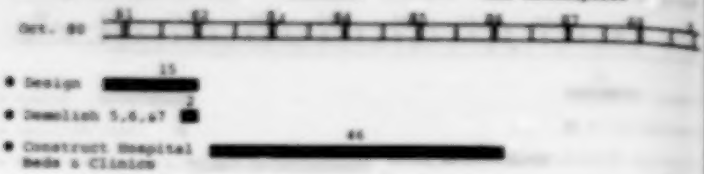
Total Elapsed Time 80 Months

Concept B Schedule VAMC Minneapolis



Total Elapsed Time 84 Months

Concept C Schedule VAMC Minneapolis



Total Elapsed Time 63 Months

CONCEPT A	New Hospital and Clinics	$ 77,383,000
	Renovation	10,700,000
	Heating-Cooling Plant (Including tunnel and distribution systems)	10,317,000
	Design Contingency 10%	9,800,000
	Escalation	48,800,000
	TOTAL ESTIMATED COST	$ 157,000,000*
CONCEPT B	New Hospital and Clinics	82,183,000
	Renovation	8,500,000
	Heating-Cooling Plant (Including tunnel and distribution systems)	10,317,000
	Design Contingency 10%	10,500,000
	Escalation	58,500,000
	TOTAL ESTIMATED COST	170,000,000*

*Does not include Group II and III Equipment, Design Fees, and Soil Analysis

CONCEPT C	**New Hospital and Clinics** 1,102,123 S.F. at 97.91 (includes sitework and demolition)	$	109,683,00
	Heating-Cooling Plant (includes tunnel and distribution systems)		10,317,00
	Design Contingency 10%		12,000,00
	Escalation to Oct. 1983 40%		62,500,00
	TOTAL ESTIMATED COST	$	194,500,00

*Does not include Group II & III Equipment, Design Fees and Soil Analysis

Concept A	**Nursing Home Beds** **Heating-Cooling Plant and Laundry** **Hospital Ancillary Base and Bed Tower**
Concept B	**Heating Cooling Plant and Laundry** **Clinics** **Hospital Ancillary Base and Bed Tower including Nursing Home Beds**
Concept C	**Heating Cooling Plant and Laundry** **Complete Replacement Hospital, Clinics and Nursing Home Beds**

ENGINEERING CONSIDERATIONS

At this early stage in planning, only preliminary consideration can be given to the several engineering systems and features of the proposed construction. Where these considerations are pertinent, or will have significant impact on the development of the concepts, they have been used in relating buildings to the site, in establishing the relationships and locations of departments and in the estimating of costs.

This section of the report presents summaries of the considerations of the various engineering disciplines. These statements are an integral part of the report and should be considered in the decision between the three concepts.

MECHANICAL CONSIDERATIONS

Concept A

The location of the new construction immediately adjacent to Building 43 creates a compact complex. However, the limited story height of Building 43 will place severe constraints and added costs on the new construction, compromising such functions as surgery, radiology, dietary and laboratory which require higher ceilings and/or larger duct systems to adequately serve these departments.

The patient bedroom floors and office type areas of Building 43, as well as the new building(s), could employ HVAC systems using lower quantities of ducted air supplemented by fan-coil units or ceiling heating/cooling panels. This concept is less demanding of space above suspended ceilings, while creating an acceptable environment in the rooms served as well as being energy efficient.

Concept B

The location of the new construction, remote from Building 43, will permit story heights of the new construction as required to adequately accommodate the intended functions of the various spaces.

If laboratory and small animal housing functions are assigned to upper floors of Building 43, larger quantities of supply and exhaust air would require larger (or more) duct systems. The limited story height in this structure provides less than 10'-0" clear from floor to bottom of beams. This would indicate the need to create several vertical shafts for supply and exhaust ducts, gas and plumbing pipes, resulting in additional costs and loss of usable floor area.

Concept C

This scheme, totally free of any constraints of existing buildings, provides the best conditions for adequately providing mechanical systems and building shell for maximum energy conservation, while creating space environmental conditions to satisfy the intended functions.

A wider choice of mechanical systems can be considered, as well as energy conservation and heat recovery features which probably would have to be compromised if confined within the constraints of Building 43 as employed in Schemes A and B.

Heating/Cooling Plant

A new heating/cooling plant for central generation of heating and cooling media with campus type distribution of steam and

chilled water will permit more efficient use of energy and operating personnel, more effective environmental control of noise and boiler emissions, better campus aesthetics, as well as improved supervision and maintenance of heating and cooling equipment.

The location is considered a good compromise with reasonable piping lengths to building(s) served while leaving prime space adjacent to the hospital complex available for parking, landscaping and future change.

The laundry, located adjacent to the heating/cooling plant, permits an efficient installation with the best potential for energy conservation, heat recovery and environmental control.

ELECTRICAL CONSIDERATIONS

Concept A

One of the transformers service Building 49 is fed from the south branch of the dual primary radial distribution system which loops around the ellipse. This loop apparently was never closed between Buildings T12 and 1. This branch would be interrupted by the construction of the Phase I ancillary and bed units. However, the transformer on the west side could be temporarily backfed from the east side of Building 49, and the feeder would remain clear of Phase I construction.

The existing electrical feeders for the entire site, both east and west of Minnehaha Avenue, intersect with the proposed utility/laundry tunnel. This tunnel's elevation will need to be designed to avoid relocation of the primary feeders.

One advantage of Concept A is that all new construction would generally start at the ends of the distribution system and work towards the source, thus minimizing service interruptions for existing buildings. This holds true for both Phase I and Phase II construction. Furthermore, the new construction in each case could be served from the same primary distribution system which had fed the demolished buildings.

Concept B

The new construction would interrupt the south branch of the primary distribution system which loops around the ellipse. To maintain continuous service to Buildings 4, 5 and 6 would require a backfeed around the north side of Building 49, for which a spare duct line already exists.

The utility/laundry tunnel intersects the primary distribution system. However, this problem is less severe with Concept B since the tunnel's more southern route intersects only the south loop around the ellipse, and not the total feed to the ellipse.

Building 43's electrical system will be impacted if research is assigned to the top floors. This would require substantial renovation to the electrical distribution system serving those areas. Furthermore, adopting a central heating/cooling concept could also drastically affect the electrical system configuration since certain mechanical loads would probably be shifted from the buildings to the new heating/cooling plant.

One advantage to Concept B is that the electrical service to the new construction could come either from the west (as a continuation of the backfed south loop of the ellipse) or from the northeast at the point where the ellipse feed branches at Manhole #6.

Concept C

Concept, C, the total replacement concept, is in approximately the same place as Concept B facilities, so that similar advantages and disadvantages may be cited for this concept.

CONCEPTS A, B AND C

Structural Framing

The structure for the new concepts can be steel frame with concrete floor, or reinforced concrete form and slabs poured in place or a combination of the two. The economics of the structure will be analyzed when the number of stories, bay sizes and loading have been determined.

Foundation types for the new structures will be determined when a complete soil exploration program has been completed.

Existing foundations for Building 43 (1953) consist of concrete piles and caps. The depth, size and capacity is not shown. From the soil boring logs, it appears that the piles are bearing on rock about 40 feet below the first floor.

Subsurface soil data at this time is available only for Buildings 43 and 49.

Foundations for building 1 (1925) are spread footings assumed bearing on sand with a bearing value of 6,000 psf about ten feet below the first floor.

All existing structures to the south appear to have spread footing foundations. Bearing values are not known, but can be assumed to vary from 2,500 psf to 4,000 psf (Building 49) to 6,000 psf for Building 1.

Seismic Considerations

The Minnesota State Building Code has waived the Zone One requirement and reclassified the state to Zone Zero.

The only structure designed for seismic is the 1976 addition to Building 1.

UTILITY CONSIDERATIONS

Concept A

Water

A total of three relocations around buildings (1,600 ft.) to continue the fire loop and domestic service to the buildings are needed. The present water pump station and tank would not be affected by the plan.

Sanitary Sewer

One relocation of the 12" line to 54th Street around the proposed boiler and laundry is needed. New connections to serve the new buildings (600 ft.) are needed. That service connects to the existing 15" sanitary sewer flowing southeast across Minnehaha Avenue.

Storm Sewer

A major new storm sewer system is to provide roof and parking lot drainage. The present system is inadequate. The new system should be extended to the river, about one half mile beyond Minnehaha Avenue. Alternative disposal could be to the Highway Department drainage for the T.H. 55 (not built or planned) or by use of a retention pond storing the runoff in excess of the present pipe capacity (24").

Gas

The site currently is served by natural gas from Minnegasco by low and high pressure lines. The new boiler plant would require a new H.P. line, and a new low pressure line for continued service to the residences along Minnehaha Avenue. Hospital service would be extended through the building to serve minor gas needs.

Steam

A new steam tunnel connection (875') would be proposed to replace the current tunnel and could be expanded to use carts for laundry transfer as well as utilities. This would allow for demolition of the older buildings now on the steam supply route to Building 43.

Parking and Access

The parking needs would be met by expansion of the southeastern lot, replacing those spaces in the northwestern lot being built upon. The present access from 54th Street and Minnehaha would be maintained. One entrance on 46th Street to the northwest lot would be maintained and the others on 46th would be closed. Internal circulation to Building 43 service court and for Building 49 would be maintained. Total parking requirements call for 2,350 spaces, a net gain of approximately 600 spaces.

Concept B

Water

A relocation of the fire loop on the south of the new building (1,450' ±) would be necessary. The present water tank and pumping station would not be affected. New fire hydrants would be placed to continue adequate hose coverage and to supply building sprinkling systems, as needed. The system around the present Building 43 and 49 would remain intact.

Sanitary Sewer

There would be one relocation around the proposed fire department/garage building (200' ±). A new connection from the new building to the present sewer, in mid-site across Minnehaha Avenue, would be made. Verification of capacity and demand should be made during preliminary design. Some sewage load can be put on the 47th Avenue line if some of the load from Building 43 is reduced due to change in space usage.

Storm Sewer

The present system around Building 43 would remain intact, and the drains from Building 49 would remain also. A new system to drain the northwest lot, northeast lot, and southeast lot is proposed as well as lines to receive roof water from the new buildings for a total length of about 6,000 ft. The main system outfall would be to the river, about 1/2 mile away and would be large size pipe. This new system should be designed with a retention pond as an alternate also so as to utilize the present outfall of 24" pipe, and as a second alternate to connect to the proposed T.H. 55 drainage system.

Gas

A new high pressure line and a relocation of the low pressure around the fire/garage building would be needed to serve the new boiler/laundry building and the residences east of Minnehaha Avenue. Other uses of low pressure gas on site for the main hospital would be connected to the existing mains and distributed internally.

Steam

A new steam tunnel connection to the new building would be needed from the new boiler plant. This could serve also to allow laundry distribution to the hospital. Connection length would be about 650'. Temporary connection to Buildings 43 and 49 through the existing system would be maintained until the new system was operable.

Parking and Access

Parking

The present northwest and northeast lots would remain and the

southwest lot would be replaced in a new location. The southeast lot would be revised and expanded. There would be no great change in traffic patterns.

Access

The access on the Minnehaha side would be revised as the north entrance would be relocated southerly. The 54th Street access would remain the same. The 46th Avenue access would close one entrance and create two new entrances. There would be no great impact on the traffic patterns.

DIETARY SERVICE

The preferred system is a centralized tray service with preparation and serving functions located in the new ancillary base where the majority of beds can be served. The station is gradually changing to this type of service, but will need to address the problem of adequate elevator transportation to make it an efficient system.

Because of location and proximity of buildings, it is not always possible to achieve the ideal relationship in the concepts presented. However, the long term objective can be met in each concept once Building 43 is replaced.

The systems will be designed to achieve the economics of operation possible, given the constraints noted. Concept A provides for the food service department to remain in Building 43 and to be remodelled for a centralized tray concept. Bulk food will be delivered to serving areas in the psychiatric bed areas and the nursing home unit.

Concept B retains the preparation and cooking areas in Building 43 with bulk delivery to a tray set-up area in the new building and the nursing home unit.

Concept C provides for totally new food service facilities. The detailed design of the systems will depend on the concept selected.

MATERIALS HANDLING AND DISTRIBUTION

Hospital materials distribution systems requirements are generally catagorized into three types:

- Bulk Material Movement
  - Linen delivery
  - Dietary meal delivery
  - Med/surgical supplies
  - Soiled linen collection
  - Trash collection/disposal
  - Medical Equipment
  - Pharmaceuticals (To satelite pharmacies)
- Demand delivery - small commodities
  - Medications
  - Medical records
  - Special medical/surgical supply items
  - X-ray film files
  - Specimen collection
- Message and paperwork
  - All types of ancillary service orders and reports.
  - Supply orders/requisitions
  - Mail-internal correspondence

Demand delivery systems and message handling systems will most certainly be required under all three of the design concepts. However, the specific requirements for these systems cannot be defined at this early development stage. Nor does the need for these systems vary significantly between the three concepts.

Bulk material movement systems/methods, on the other hand, requir planning of specific space relationships and routes and must be considered in this early planning phase.

This materials handling section, therefore, addresses only bulk materials handling.

Cart/Equipment Movement

The movement of patient meal carts from the main kitchen to the inpatient units represents 35 to 45% of the total cart traffic in the hospital. This traffic must occur at specific times during the day. For these reasons, the movement of these carts is a primary consideration in selection of cart delivery systems/methods.

In concept A, the main kitchen remains on the 3rd floor of building 43. The horizontal distance from the main kitchen to the vertical core serving the new beds is approximately 400 feet.

Automation of this horizontal movement is not recommended. To do so would require a completely separate corridor connecting the core with the main kitchen.

Designated service elevator(s) are recommended for vertical cart movement in the new bed tower.

Automatic inject/eject cart elevators are an alternative which may be considered. Use of this type of equipment requires that all carts have the same base dimensions and caster size/configuration. Since these lifts would be used for linen carts, supply carts, soiled collection carts as well as dietary meal carts, this places a significant constraint on the operation of these other departments.

The existing service elevator in building 43 would provide reasonable service to the bed areas remaining in this building.

Concept B strongly suggests the use of an automated or mechanized cart system for horizontal cart traffic between building 43, the new ancillary building, the new bed towers and possibly the laundry.

To facilitate a mechanized/automated cart system which will serve dietary would require a basement level connector from the south end of building 43 to the new ancillary building and to the vertical cores serving the nursing towers. An elevator would be required at the south end of building 43 to move dietary carts between 3rd floor and basement connector.

A system such as Amscar by AMSCO should be considered. This system offers greater flexibility in design, requires lower capital investment and has a more satisfactory history of performance when compared to other automatic cart systems.

The Amscar system can be extended to include vertical movement by providing designated elevators at appropriate locations. This would probably be economically justifiable in the nursing towers.

Concept C is a total replacement of the existing facilities and horizontal travel distances for carts is significantly less than those under Concept A or B.

An automatic horizontal cart system is not justified under this concept. By locating dietary and supply departments in close proximity to the vertical cores, horizontal travel can be short.

A tow vehicle system would appear logical for linen cart traffic to/from the laundry.

Automatic inject/eject cart elevators or separate designated service elevators for cart/equipment movement should be provided in both of the nursing towers under this scheme.

Trash/Linen

A twin tube type gravity pneumatic trash and linen collection syste should be considered for all new construction. The discharge from the system to be located at the laundry power plant facility.

Pneumatic systems minimize hospital environment contamination and the handling of trash soiled linen by employees.

The U.S. Environmental Protection Agency has recently proposed that all hospital wastes be sterilized or incinerated prior to disposal in landfill.

The best location for an incinerator is adjacent to the power plant, remote from the hospital. Waste heat can be recovered and utilized in this location and incinerator stack odors and emmissions would not be picked up at hospital air intakes, etc.

SPD-Surgery

A direct vertical relationship of S.P.D. to surgery can be achieved in all three concepts. This is highly desirable. Automatic cart lifts (separate clean and soiled) between these two departments will allow for efficient centralization of processing and for the adoption of a surgical case cart system.

Mr. Steinberg. Thank you. We will leave it to all of you to be in touch with Dr. Baganz or his representatives to obtain those copies.

We wanted to make sure that the maximum amount of information is, in fact, flowing.

I might mention that Mr. Hansen of the West Metro Hospital Trustees Council public policy committee was here today. He had to leave to catch a plane. We would like them included in that process, please.

Maury, with respect to your comment about the additional $15.5 million cost being the result of any slippage from the fiscal year 1981 to 1982 or later schedule, it is our understanding that you proposed an outlay in fiscal year 1981 of $5.6 million. Could you explain why it is necessary to appropriate more than that amount at this point; and that in view of the outlay of $5.6 million, why you are projecting an additional cost of $15 or $15.5 million if the project slips to fiscal year 1982?

Mr. Cralle. Certainly. We are talking about two different things. I referred to $15.5 million which would be budget authority for the total project; when you built the whole project, assuming that you would build, eventually you spend from the Treasury an additional $15.5 million.

Mr. Steinberg. The question is why, if you are only going to spend $5.6 million in fiscal year 1981 in any event out of the $15 million that you have requested for fiscal year 1981, why there would be an additional approximately $10 million that would be entailed—I take it you're talking about additional inflation over the $221 million figure?

Mr. Cralle. That's right.

Mr. Salmond. I am Mr. Salmond, the Assistant Administrator for Construction.

We would need the $15 million because we need it for obligation purposes. If you recall, we schedule a demolition portion of the project in September 1981.

Mr. Steinberg. That's 1-month slippage—that is the last month of fiscal year 1981.

Mr. Salmond. That's correct. But you need it to obligate it.

Mr. Cralle. I detect that this answer hasn't satisfied you. Perhaps I can explain. We need to have the project authorized in the 1981 fiscal year so that we can begin on the project and begin to obligate moneys.

Beginning to obligate moneys in the beginning of the planning process is distinctly different from the outlay flow which comes from the Treasury.

If it is not authorized in 1981, we will not be able to obligate moneys against that. We will be caused to be delayed. That delay will in total add some $15.5 million to the total cost of the project over the life of the project, and it is due to inflation. That number comes from an inflation factor.

Mr. Steinberg. It would be helpful to us if you would give us an obligational schedule for the $15 million that you are presently requesting in budget authority as soon as possible.

[Subsequently, the Veterans' Administration furnished the following information:]

	Obligations (millions)
Fiscal year 1981:	
Demolition and utility relocation (September 1981)	$4.0
Technical services (October 1980)	7.7
Subtotal	11.7
Fiscal year 1982: Excavation and foundation, new building (December 1981); structural frame, new building (May 1982); energy plant (July 1982)	51.2
Fiscal year 1983: Complete new building (January 1983)	131.3
Fiscal year 1986: Sitework and demolition (July 1986)	7.5
Various years (fiscal years 1981–90: Contingencies for design and construction contracts, utility agreements and other services (an undetermined portion of this contingency fund will be required in fiscal year 1981)	10.7
Total, project costs	221.4

Mr. **Steinberg**. Let me clarify, if I may, so that our terminology will be understood and we can be talking about the same subject, that when you refer to authorization in fiscal year 1981, I believe what you are talking about is appropriations—budget authority given to you in fiscal year 1981.

Mr. **Cralle**. No, sir, I am not. When I refer to authorization, I refer to the authorization for this project line. We will then get from the Appropriations Committee a $15 million authorization. We will begin to obligate against this authorized project.

Mr. **Steinberg**. Unless the Congress appropriates $15 million, any authorization action by this committee, or the House committee, will be of no value to you.

Mr. **Cralle**. That's right.

Mr. **Steinberg**. That's what I'm saying. We are not talking about authorization. We are talking about the appropriation of $15 million in fiscal year 1981 which, if not made, according to what you have just told us, will end up costing us at the end of this project a like sum in inflation.

Mr. **Cralle**. Yes.

Dr. **Baganz**. What we understand is that this committee is the authorization committee, and before the Appropriations Committee could give us the $15 million, you have to pass a resolution such as the House has stated.

Mr. **Steinberg**. There are two things wrong with what you just said. No. 1, the Appropriations Committee doesn't give you any money. Appropriations bills have to go through the entire Congress. And, No. 2, the House and Senate Appropriations Committees are free to do whatever they wish to do in terms of what they recommend to the House and Senate, respectively. The appropriations bill is then subject to point of order on either floor if both authorizing committees have not passed a resolution authorizing a project included in the bill.

However, if no point of order is made, it is not self-executing and an appropriation for such project could, therefore, be made in the appropriations bill by either body.

Again, what I am saying to you is that it's the appropriation that you need of $15 million. As an orderly prerequisite to that, you also need an authorization resolution by each of the two committees.

I don't know if that helps or hurts in terms of clarification for those that may be less familiar with the Congressional budget process.

Mr. CRALLE. My understanding is that we have four committees and we have to get them in agreement to move ahead.

Mr. STEINBERG. We are glad that you accord that degree of priority to this committee's operations.

Mr. Peck, you referred to bed sizing and the GAO model. It is our understanding that the bed sizing model that is used for a replacement hospital is different from the bed sizing model that is used for new construction such as in California where you built a new hospital.

Mr. PECK. We actually have no model for new construction. In Camden we used the Philadelphia VA hospital and the outlying hospitals. We sized those hospitals and said there was enough room in them, therefore, we did not need to build Camden because it was only 7 miles away.

Mr. STEINBERG. So, the agreed upon methodology which was 3 or 4 years in the making applies to replacement facilities?

Mr. PECK. Right.

Mr. STEINBERG. How did you utilize that insofar as the 120 nursing beds were concerned since those are new beds, not replacement beds?

Mr. PECK. We have no provision for nursing home beds in the model except for those which would replace existing acute care beds. For additional nursing home needs, we accept whatever VA offers.

Mr. STEINBERG. The VA says they are not nursing beds in the traditional sense, but what we would call intermediate care beds, or beds in the medicare model for example. That was one of your major contentions throughout the bed sizing disputes that took place.

Did you make an attempt to look at this, instead of as a hospital and a nursing home, as a facility of some almost 1,000 beds rather than the present number of beds that are there now?

Mr. PECK. No.

Mr. STEINBERG. In view of the VA's contention, both in their statement today and in the overview, that these are really not skilled nursing beds, but beds at a higher level of care, do you think that you could reassess that issue for us?

Mr. PECK. We probably could. I'm really not aware of what position they are taking.

Mr. STEINBERG. Have I correctly stated your view?

Dr. BAGANZ. They are apples and oranges that you are mixing up as to what the GAO bed sizing model and what the report on the aging veteran model has in it.

Mr. STEINBERG. For this facility, have you told us that the 120 beds would be a higher level of care than just skilled nursing beds?

Dr. BAGANZ. That's what they are. But we did not discuss that and it is not part of the GAO bed sizing model, except beds that do not fit the PAS length of stay days. The bed sizing includes allocation of these days of care to lower levels of care, viz ambulatory nursing home or whatever. These may be part of that requirement for beds in the nursing home category. This is not the way the bed requirements were arrived at as to the 120 nursing home beds as separate from the hospital bed requirements.

These nursing home beds are not out of the GAO sizing model.

Mr. **Steinberg.** I'm suggesting that perhaps in view of the purpose that you prescribed to those beds they ought to be looked at insofar as the bed sizing model is concerned. If I understood what you told us, the community nursing home beds which you contract for, would continue at about the present rate which I believe is some 180 contracts at present.

Dr. **Baganz.** That's different too. That's on a percentage. There are now 44,000 veterans in that area over age 65. By 1990 it will be 110,000 veterans over age 65. They not only require additional days of short term acute care, but more nursing home care beds days.

As we updated the GAO bed sizing model for 1990 over 1985, we created a requirement for 134 more acute medical-surgical-psychiatric beds independent of the nursing home allocation. That could be picked up in part by the new nursing home care program component. This could further back into the Aging Veteran Report which developed and uses an entirely different methodology of dealing with veteran population and needs.

The veteran population in nursing homes that is, currently being served by the VA funds, is 18 percent of all veterans in nursing homes. We propose that 40 percent of those requirements would be met by in-house VA, 40 percent by the community homes, and 20 percent by the State home programs.

Mr. **Steinberg.** What I just heard you say, and you have succeeded in confusing me, or at least having that effect, is that, in your 1990 projection, you are in effect projecting a need for some 130 or 140 more acute care beds, and that you took that into account in your model. The only way I can think of that you did that, is that you included the 120 nursing home beds in those which would pick up people who are now in your hospital beds getting a lower level of care, which we call intermediate care, and thereby you will have more acute beds with the same number of beds which are now designated hospital beds.

Dr. **Baganz.** No, it's a different process for different workloads. In the Minneapolis area, the VA determined there is a need for 328 in-house nursing home VA beds. We currently operate 169 beds at three other medical center sites. The 120 will bring us to 289 beds of the 328 beds of projected need.

Mr. **Steinberg.** Are you talking about nursing beds?

Dr. **Baganz.** The nursing home care beds of the VA. When we build this 120 on top of what we have we would still not meet the 100 percent planned need for nursing home care beds for this geographic area.

Mr. **Steinberg.** Except they are not nursing home care beds.

Dr. **Baganz.** The 120 nursing home care beds happen to be in this hospital structure.

Mr. **Steinberg.** I think George understands the concerns that we are expressing. I think we are almost right back into the same semantical problem that we had that led to a 3-year delay on agreeing to a bed sizing model. If you would have your people take a look at this issue, George, it would be very helpful to us. It appears to us at this point that the patients that would be transferred to the new

120 nursing home care beds would very likely be individuals that would have been in the hospital receiving an extended kind of care in hospital beds. But the net effect here is an additional 120 beds, or slightly less than that, in the community than they now have.

If we're mistaken in that, please, correct it for the record. But we would like your people to take a look at that possible hypothesis.

[Subsequently the General Accounting Office supplied the following information:]

The GAO model does not estimate the entire nursing home bed requirement for a VA hospital. It does, however, estimate the portion of the nursing home requirement which would substitute for acute care beds in the existing VA hospital. If nursing home care beds were readily available, some VA hospital patients could be transferred to these beds at the conclusion of the acute care portion of their hospital stay, thus freeing-up the expensive acute care setting for more critically ill patients.

For the Minneapolis VA Hospital, the GAO model estimated a need for 41 nursing home care beds and 32 convalescent care beds which would substitute for acute care beds. These 73 beds represent part of the overall nursing home requirement for veterans residing in the area.

VA did an independent analysis of veteran nursing home needs nationwide and projected a requirement for a 120 bed VA nursing home care unit in Minneapolis. VA's programming for the new VA hospital assumes that the 73 nursing home beds and convalescent care beds projected by the GAO sizing model are included among the 120 bed nursing home requirement arrived at separately. This assumption is consistent with the GAO's sizing method.

Analysis of the Minneapolis VA Hospital project using the GAO sizing model yields the following bed requirements in 1985:

	Beds (rounded)
Medical:	
Internal medicine (acute care)	240
Intermediate care (nonacute care)	30
Rehabilitation (nonacute care)	30
Subtotal	300
Neurological:	
Neurology (acute care)	40
Gereatric center (nonacute care)	[1]10
Subtotal	50
Surgical	280
Subtotal	280
Psychiatric:	
Acute psychiatry	65
Nonacute psychiatry	30
Subtotal	95
Total hospital	725

[1] New service to be provided in replacement hospital.

In addition to the hospital beds shown above, the GAO model estimates a need for 41 nursing home and 32 convalescent care beds mentioned earlier to substitute for part of the current acute care workload. VA will satisfy this need along with other nursing home care needs with construction of a 120 bed nursing home care unit. Overall, VA's hospital request is in close conformity to the GAO sizing model estimates.

Mr. STEINBERG. I would like to ask the representative of the HSA this question. The VA, in both its initial testimony and its rebuttal, made the point that it is serving much more than 7 counties—indeed anywhere from 70 to 82, depending upon whose estimate you look at, including counties outside of the State. Does not the medical school hospital also serve a catchment area larger than the seven counties, and how would you take that into account in your certificate-of-need review of that facility?

Second, is it unusual for you to be reviewing facilities for certificates-of-need which have catchment areas that are larger than your specific seven counties?

Mr. **Mitchell.** To answer the second question first, it is usual for us to factor in in-migration or persons using the facility from outside the seven county metropolitan area, and we do that primarily by the use of analyzing what we term patient origin study information, where we do collect on a routine basis, at least traditionally we have collected on every 2-year period information on where patients come from to use hospitals within the seven-county area.

The last time the VA participated, that was in 1974. My understanding now is that we have last Wednesday, we did reecive from the VA updated information from 1976 and 1978 on where their patients came from. And that is how we factor in the use of the service by persons outside of that area. We do it for the University of Minnesota which also has approximately 40 percent of patients from the metropolitan area and about 60 percent from outside the metropolitan area.

Mr. **Steinberg.** In that respect, the university's situation is very similar to the VA's?

Mr. **Mitchell.** Correct.

Mr. **Steinberg.** Maybe Mr. Dickler would like to address this issue.

Mr. **Dickler.** Just to be a little more precise. The university hospital receives approximately 46 percent of its admissions from the metropolitan area. Approximately 35 percent from the rest of the State of Minnesota, and approximately 19 percent from other States than Minnesota.

Mr. **Steinberg.** That does not sound significantly different from the figures that the VA gave us with respect to their catchment area.

Mr. **Dickler.** It is my understanding it is very similar.

Mr. **Steinberg.** So the HSA will take that into account in making its certificate-of-need recommendation for the university and will likewise take it into account in making any formal recommendation with respect to the VA facility?

Mr. **Dickler.** Yes.

Mr. **Steinberg.** Does anybody want to add a point or ask a question on this issue?

Ms. **Kiehne.** I have one question. I would like to know what percentage of patients treated come from the 7-county metro area versus the other 65 counties?

Mr. **Cooney.** It varies between 48 and 62 percent.

Mr. **Steinberg.** Are you talking about both inpatients and outpatients?

Mr. **Cooney.** All patients.

Dr. **Hanson.** The community hospitals also have in-migration from outside the seven-county area, and specifically the hospital where I practice has an in-migration of about 25 percent from outside of the seven-county area of our HSA and about 5 percent from outside the State, so it's one of degree. In patient origin the VA and university are quite similar, and several other community hospitals, that are reviewed by the HSA, have significant in-migrations.

Mr. **Steinberg.** I haven't forgotten that you want to add a few personal comments, but let's hold up for a moment if we can.

Mr. Dickler, a suggestion was made by Ms. Kiehne that their organization, at least preliminarily, thinks that one alternative to a replacement hospital would be some kind of a purchase of services, presumably from the under-utilized beds in the community. Would you like to comment on that from the standpoint of your relation to the VA insofar as the medical implication is concerned?

Mr. **Dickler.** The response would be primarily in terms of the relationship of the Veterans' Administration hospital and the academic units of the university. As I mentioned earlier, there has been a very long and satisfactory relationship between the university and Veterans' Administration hospital in both education and research. The advantage, clearly, of the Minneapolis VA hospital is that as a major affiliate of the university it provides a single site for a larger amount of clinical medical education, and that there is a very strong relationship between the staff of the Veterans' Administration hospital and the university. For example, the vast majority of the medical staff of the Veterans' Administration hospital have faculty appointments at the university.

I cannot speak for the medical school or the other academic units in terms of what a distribution of those patients to all of the hospitals in the metropolitan area would mean for the medical education program, except to simply say that it is unlikely that the same type of quality control focus for those clinical educational programs and relationships between the medical staff could be maintained in that type of relationship.

Mr. **Steinberg.** Would you like to discuss that with the dean and perhaps give us a more fulsome answer for the record?

Mr. **Dickler.** Yes.

Mr. **Steinberg.** You might also, in that regard, and I think the data is probably available, include the extent to which your graduates are serving the needs of the State.

I wonder if I could ask Mr. Mitchell a couple of questions. You are having your hearing no later than Apirl 30, I believe you said, in connection with the VA project, and you spoke of having some kind of a recommendation by early May.

Mr. **Mitchell.** Correct.

Mr. **Steinberg.** That would be made public in early May?

Mr. **Mitchell.** Correct.

All of the process to date is already public. We can keep you informed of all preliminary documents as well, but the final recommendations would be made subsequent to the hearing on April 30.

Mr. **Steinberg.** As I understand it, you'll take a position on the VA facility in early May and then you will proceed in August or September formally to consider the university application. The university cannot proceed without a certificate-of-need, whereas the VA can proceed if the funds are appropriated by the Congress, without regard to your recommendation.

Once the VA model is established, does not that significantly alter the options open to you insofar as the certificate-of-need process for the university facility is concerned?

Mr. Mitchell. The short answer is yes. The decisions made, or the recommendations made related to the veterans hospital do, in some ways, reduce the options which are at a future time available for the university. And that is one of the reasons there is as much energy being put into this part of the process now as is being done by the local health board.

The outcome of those, I think, are still in the decisionmaking process, and I can't prejudge those. But it does limit some of the options available if a decision is made relative to the VA.

Mr. Steinberg. Mr. Dickler, who is going to pay for your facility?

Mr. Dickler. At the present time, our proposal is to try and obtain State general obligation bond funding for the project which would then be repaid by the university through patient care charges. So, in effect, the patients that utilize the university hospital would pay for the construction program. But hopefully we will use the State financing mechanism to reduce the overall debt charges that result from the construction program.

Mr. Steinberg. That's something we here in Washington call off-budget. Is that the correct terminology for that? Maury, is that right?

Mr. Cralle. I don't think I want to touch State budgeting.

Mr. Steinberg. Your facility, is now estimated to cost in the vicinity of $250 million, is that correct?

Mr. Dickler. Hopefully it will be a little less than that. We have been operating with a budget estimate at a little over $220 million, but those were developed before the latest inflationary rates seem to have stabilized, so it may be escalated. We're not sure what it will cost until we see what inflation does over the next 18 months.

Mr. Steinberg. That is for approximately 500 beds that you will be replacing?

Mr. Dickler. Five hundred beds, some support services, and other remodeling in existing facilities.

Mr. Steinberg. I would like to ask the VA to provide us with some information for the record. The representative of The American Legion, Department of Minnesota, made the point that it is very significantly advantageous to the veterans in the hospital as well as the organizations themselves, to have a VA facility located as close as possible to a regional office.

I wonder if you could please give us a list of the existing medical centers that are located in the same general proximity as regional offices at present, and also provide us with an indication as to how that factor was taken into account for the most recent replacement hospitals that are now in various stages of approved planning or that were constructed in the last several years?

Mr. Cralle. We'll do that, yes.

[Subsequently, the Veterans' Administration furnished the following information:]

The attached list identifies the VA Medical Center nearest each Regional Office and the approximate distance between the facilities. Mileage is also provided for separated VA Medical and Regional Office Centers.

Regional office	Nearest VA medical center	Approximate distance (miles)
Eastern:		
Atlanta	Atlanta	6
Baltimore	Baltimore	4
Boston	Boston	4
Buffalo	Buffalo	4½
Columbia	Columbia	7
Hartford	Newington	7
Huntington	Huntington	6
Manchester	Manchester	3
Newark	East Orange	4½
New York	New York City	1
Philadelphia	Philadelphia	6
Pittsburgh	Pittsburgh	2
Providence	Providence	3
Roanoke	Salem	6
San Juan	San Juan (VAM and ROC)[1]	4
St. Petersburg	Bay Pines	12
Togus	Togus (VAM and ROC)[1]	
Washington	Washington	2
White River Junction	White River Junction (VAM and ROC)[1]	
Wilmington	Wilmington (VAM and ROC)[1]	
Winston-Salem	Salisbury	39
Central:		
Chicago	Chicago (West-side)	5
Cleveland	Cleveland (Wade Park)	7
Des Moines	Des Moines	5
Detroit	Allen Park	13
Fargo	Fargo (VAM and ROC)[2]	1½
Indianapolis	Indianapolis	1½
Jackson	Jackson (VAM and ROC)[2]	4
Lincoln	Lincoln	5
Little Rock	Little Rock	5
Louisville	Louisville	4
Milwaukee	Wood	6
Montgomery	Montgomery	5
Muskogee	Muskogee	2
Nashville	Nashville	1½
New Orleans	New Orleans	½
St. Louis	St. Louis (Cockran Division)	1
St. Paul	Minneapolis	½
Sioux Falls	VAM and ROC	3
Wichita	VAM and ROC	3
Western:		
Albuquerque	Albuquerque	13
Anchorage	Consolidated OPC	
Boise	Boise	¼
Cheyenne	Cheyenne (VAM and ROC)[1]	
Denver	Denver	11
Fort Harrison	Fort Harrison (VAM and ROC)[1]	
Honolulu	Consolidated OPC	
Houston	Houston	2
Los Angeles	Los Angeles (Wadsworth/Brentwood)	½
Manila	Consolidated OPC	
Phoenix	Phoenix	½
Portland	Portland	3
Reno	Reno	2
Salt Lake	Salt Lake City	6
San Diego	San Diego	12
San Francisco	San Francisco	8
Seattle	Seattle	4
Waco	Waco	5

[1] Medical center and regional office located geographically together.
[2] Medical center and regional office separated geographically.

Mr. STEINBERG. Mr. Cooney, it was also stressed that there seems to be a disproportionately high number of disabled Vietnam veterans in the Minnesota area served by your facility. Do you have an estimate of the proportion of inpatients and outpatients who are Vietnam veterans or Vietnam-era veterans at your facility?

Mr. COONEY. I think it was included in the data. I don't have that figure.

Mr. STEINBERG. Herb, perhaps you could, in isolating that for us, compare it to the systemwide data and also the systemwide data for major metropolitan areas if that is possible.

Dr. **Baganz**. It is in the document. Minneapolis versus systemwide is in there.

[Subsequently, the Veterans' Administration furnished the following information:]

A recent systemwide cost comparison study was made for medical and surgical patients and showed that, during the period October 1, 1977, through September 30, 1978, each episode of VA care cost approximately seven percent less than purchasing that care in the community.

This comparative episode of care cost advantage results from the fact that the VA cost per patient day is substantially less than those of community hospitals.

The systemwide savings during fiscal year 1978 amounted to $195,870,676. The following table shows how these savings were computed.

Cost saving due to providing care in VAMC's rather than purchasing care in community hospitals

Total episode of medical and surgical care fiscal year 1978[1]	$1,138,78
Savings per episode[2]	$172

Total fiscal year 1978 savings $1,138,783×$172=$195,870,676

[1] Episodes of care provided in medical and surgical bed sections of VAMCc classified as GM&S facilities in fiscal year 1978. Table 18, p. 125, Annual Report, 1978, Administrator of Veterans Affairs.

[2] Savings per episode from DM&S fiscal year 1978 Update of the 1977 VA Medical Care Cost Comparison Study, Table 1.

ESTIMATED VIETNAM ERA VETERANS VERSUS TOTAL VETERAN POPULATION

[In thousands]

	June 1976	September 1977	September 1978	September [illegible]
Nationwide:				
Total veteran population	29,607	29,844	29,984	[illegible]
Vietnam era veterans	8,070	8,474	8,734	[illegible]
Percent of total	27.3	28.4	29.1	[illegible]
Minnesota:				
Total veteran population	549	553	556	[illegible]
Vietnam era veterans	170	179	185	[illegible]
Percent of total	31.0	32.4	33.3	[illegible]

Source: Veteran population by age, State of residence and regional office, by period of service. Reports and Statistics Service, Office of Controller.

Mr. **Steinberg**. What attachments are you referring to?

Dr. **Baganz**. That would be, there is a data base—I can obtain it out for you.

Mr. **Steinberg**. That would be helpful. I think it would be helpful in making this volume a little more usable if you could provide just a little table of contents of the attachments themselves.

Dr. **Baganz**. I agree with you. As a matter of fact on the front page of mine I have made an index because that is missing.

Mr. **Steinberg**. If you could have that officially added to it in the copies that you send to people, I think it would help them a lot rather than having to go back and fish through the text to pickup the cross-references.

I wonder if we could focus for a moment on the projected use, for 9 years, of building No. 43, which I believe was built in the early 1950's. That building is a standard model hospital, I believe, of which there are some seven others in the system which are built virtually identical in design. Is that correct?

Mr. **Cralle**. It is kind of a standard model. I'd have to count them. I couldn't verify it——

Mr. Steinberg. Are there somewhat more than seven? Am I too low on that?

Mr. Salmond. It's about 13.

Mr. Steinberg. Is that the same design from which Fresno was built?

Mr. Salmond. No, I don't believe so. The others are St. Louis, Oklahoma City, Cincinnati, Philadelphia, Kansas City——

Mr. Steinberg. Please describe for the record where you stand on your planning for the replacement of each of the other facilities of the same design.

[Subsequently, the Veterans' Administration furnished the following information:]

The following represents our typical 500-bed acute care prototype constructed post-World War II by the VA and the Corps of Engineers:

VAMC	Construction completed	Activated
Ann Arbor, Mich	July 1953	October 1953.
Chicago (Westside), Ill	May 1953	September 1953.
Cincinnati, Ohio	March 1954	May 1954.
Denver, Colo	July 1951	August 1951.
Indianapolis, Ind	November 1951	February 1952.
Kansas City, Mo	June 1952	October 1952.
Louisville, Ky	January 1952	April 1952.
Minneapolis, Minn	June 1953	June 1953.
Oklahoma City, Okla	do	September 1953.
Philadelphia, Pa	August 1952	January 1953.
St. Louis, Mo	November 1953	March 1954.
Syracuse, N.Y	February 1953	June 1953.

Mr. Steinberg. Does that facility model contain a basic ward structure with 8 or 12 or 16 beds, or does it contain a semiprivate kind of room structure?

Mr. Martin. It's very little patient privacy.

Mr. Steinberg. I'm speaking only of building 43 now, not the outlying units built in 1927.

Mr. Martin. Just building 43. It is a basic "H" shaped structure. It does provide very little patient privacy. It has 16-bed wards, this sort of thing. It has since been carved up into smaller patient rooms to some limited extent.

One of our problems is that by the time you put patient privacy into a wing that is an operating nursing unit, the unit is so small that it is inefficient and costly to operate. In other words, if we apply patient privacy to the current commission standards today, which we are expected to do, then we get down to about 28 to 30 beds, and when you have to staff that small of a unit it becomes extremely costly.

Mr. Steinberg. How many units are there in that building?

Mr. Cooney. 420.

Mr. Steinberg. What percentage of occupancy do you have now? What is the average daily census in that building?

Mr. Cooney. It would be very high. I don't have it broken down by building.

Mr. Steinberg. Would it be approximately 80 percent?

Mr. Cooney. Maybe 85 percent.

Mr. Steinberg. Could you break down for us, for the record, the numbers of patients that are in different configurations—8 person wards, 12 person wards, semiprivate type of rooms, and semipriva types of rooms based on temporary alterations?

Mr. COONEY. Basically we have four private rooms on each of the wards in that building. The remainder are 4-bed and 16-bed rooms.

Mr. STEINBERG. In essence there are no double occupancy?

Dr. PETZEL. There is an occasional double occupancy but the ba configuration in that building is two to four semiprivate rooms an it varies from ward to ward. Two 4-bed wards and two 16-bed wards.

Mr. STEINBERG. Please break that down for us, and also break it down, if you would, by G.M. & S. and psychiatry.

Your present plans are to access that land and the building with it upon completion of the replacement hospital?

Mr. CRALLE. That's correct.

[Subsequently, the Veterans' Administration furnished the follo ing information:]

Ward and type	Private rooms	Semiprivate rooms	Large ward	Total rooms	
3A: Surgery	12	3 (4 beds each)	16 beds	16	6
4AW: Surgery	12	4 (4 beds each)	16 beds	17	6
5B: Surgery	12	4 (1 room, 6 beds; 3 rooms, 4 beds each)	16 beds	17	6
5AW: Medicine	12	4 (1 room, 5 beds; 3 rooms, 4 beds each)	16 beds	17	6
6AE: Medicine	5	2 (4 beds each)	2 rooms (16 beds each).	9	6
6AW: Medicine	5	2 (4 beds each)	2 rooms (16 beds each).	9	6
6B: Medicine	11	4 (1 room, 5 beds; 3 rooms, 4 beds)	16 beds	16	6
7AW: Psychiatry	4	12 (10 rooms, 2 beds each; 2 rooms, 3 beds each).	None	16	3
7B: Psychiatry	10	8 (4 rooms, 2 beds each; 4 rooms, 3 beds each).	None	18	3
8B: Psychiatry	6	15 (11 rooms, 2 beds each; 3 rooms, 3 beds each; 1 room, 4 beds).	None	21	4

Mr. STEINBERG. How many stories are there in the structure?

Mr. CRALLE. Nine stories.

Mr. STEINBERG. Are there beds throughout all nine stories, or ar some of them administrative floors?

Mr. COONEY. Yes. It's a combination. Administrative, diagnostic areas, and patient areas.

Mr. STEINBERG. Could you give us a brief idea now, and in more detail for the record, of what alternatives in planning the agency has considered insofar as the use of building No. 43 is concerned? That is, was it considered for use as an outpatient facility?

At present you have, I believe, two separate outpatient clinics. One for service-connected and one for non-service-connected patients. Was it considered for the nursing care beds? Can you respond to that now briefly, or would you rather wait?

Mr. CRALLE. Let me ask Mr. Martin to respond.

Mr. MARTIN. Two of the three options included the use of bedding in building No. 43. We understood we would use it all along. Our assumption was if we stayed at that site we would use that facility.

Mr. STEINBERG. Your assumption up until what point?

Mr. MARTIN. Up until the point where all the alternatives were turned in and the independent consultants presented us with the cost estimates.

Mr. STEINBERG. The cost estimate that we were provided with by letter of April 2 stated that replacement and renovation would cost only $600,000 less than total replacement.

Mr. MARTIN. That is correct.

Mr. STEINBERG. However, that is a different configuration of replacement.

Mr. MARTIN. Yes, that is comparing it to new construction. Our problem is, we could spend roughly the same amount of money and we would still end up with a facility that did not meet the requirements of modern patient care. And we would still end up with a multiple facility site. The biggest difference is that the buildings are basically totally depreciated, if we consider the fact that mechanical, electrical, electronic, is say, 65 percent of the total cost.

Well, when we renovate one of these facilities, all of that has to be replaced and then by the time you get done renovating, moving walls, to meet commission requirements for patient privacy, new services, you're right up there to where new construction costs the same amount, so it was at that time that because of only $600,000 difference in a $21 million project, we elected to go with new construction and would excess further use or surplus, the existing building 43.

Mr. STEINBERG. What would building 43 have been used for in that renovation plan?

Mr. MARTIN. Basically, and we can forward to you the studies that show that, but basically, the first few floors were to be a warehouse, supply functions, administration, management, that sort of thing. There would be one floor that would be psychiatric outpatient and inpatient services. Two floors, and then the top floors would have been medical research.

Mr. STEINBERG. You would have then abandoned building 49?

Mr. MARTIN. No. We would have had 49 also.

Mr. STEINBERG. I think you only mentioned seven floors.

Mr. MARTIN. There are two floors of psychiatric, an additional floor of support services.

Mr. STEINBERG. It was never contemplated to use it for nursing beds?

Mr. MARTIN. Not nursing.

Mr. CRALLE. You get too many functional deficiencies when you do that. You have a big houseful over here and an old building 43 and a long tunnel to walk through to go between the two of them. So we were never driven to save building 43. The cost came up so close that it is in the interest of the taxpayers and the veterans, I think, to build a total functional up-to-date facility.

Mr. STEINBERG. How many of your nursing homes are physically separate from the hospital itself where they are located in proximity to the hospital?

Mr. CRALLE. We'll have to furnish that for the record.

[Subsequently, the Veterans' Administration furnished the following information:]

Question No. 11.—Provide a listing of the number of facilities with nursing homes which are (1) part of the hospital building, and (2) separate but adjacent to the existing hospital building.

The following VAMC's have nursing home care beds which are located in separate buildings (i.e., buildings which do not house hospital beds):

Alexandria, LA
Asheville, NC
Augusta, GA
Battle Creek, MI
Bay Pines, FL
Bedford, MA
Biloxi, MS
Bonham, TX
Buffalo, NY
Butler, PA
Canandaigua, NY
Castle Point, NY
Chillicothe, OH
Cincinnati, OH
Cleveland, OH
Dayton, OH
Houston, TX
Jackson, MS
Knoxville, TN
Lebanon, PA
Lexington, KY
Little Rock, AR
Long Beach, CA
Lyons, NJ
Manchester, NH
Montrose, NY
Mountain Home, TN
Palo Alto, CA
Perry Point, MD
Phoenix, AZ
Salem, VA
Salisbury, NC
Sepulveda, CA
St. Louis, MO
Togus, ME
Tomah, WI
Tuscaloosa, AL
Tuskegee, AL
Waco, TX
Wilmington, DE

The following VAMC's have nursing home care units which are located in buildings also housing hospital beds:

Albany, NY
Albuquerque, NM
Allen Park, MI
Altoona, PA
American Lake, WA
Beckley, WV
Big Spring, TX
Brockton, MA
Brooklyn (St. Albans), NY
Cheyenne, WY
Coatesville, PA
Columbia, MO
Columbia, SC
Danville, IL
East Orange, NJ
Erie, PA
Fargo, ND
Fayetteville, NC
Fort Howard, MD
Ft. Lyon, CO
Ft. Wayne, IN
Grand Junction, CO
Hampton, VA
Indianapolis, IN
Iron Mountain, MI
Kerrville, TX
Lake City, FL
Leavenworth, KN
Loma Linda, CA
Marion, IN
Miami, FL
Miles City, MT
Murfreesboro, TN
Northampton, MA
North Chicago, IL
Pittsburgh (GM), PA
Poplar Bluff, MO
Reno, NV
Roseburg, OR
Salt Lake City, UT
San Diego, CA
Sioux Falls, SD
St. Cloud, MN
Syracuse, NY
Topeka, KN
Tucson, AZ
West Haven, CT
White River Jct., VT
Wood, WI

The following VAMC's would fit into each of the above categories in that they have a portion of their nursing home care beds in separate buildings and the remainder in buildings which also house hospital beds.

Bath, NY
Dublin, GA

Dr. Baganz. We attempt to build nursing home care units on the first floor in nonrenovated space because of the compromises we have to make if we put them above the first floor. The same thing holds for one other program, spinal cord injury.

Mr. Steinberg. I understand that. That's not an answer to the question.

Mr. Cralle. The question was nursing homes with hospitals. It is department policy to put nursing homes colocated——

Mr. Steinberg. I'm trying to find out the extent to which department policy was complied with in terms of existing facilities and new construction.

Dr. Baganz. There is no policy, Jonathan, as to whether the nursing home is within the shell or adjacent and free-standing. The pattern has been, however, that they are in a free-standing attached appendage to the new hospitals. But there is no policy.

Mr. Steinberg. That is the reason for the tunnel Maury just referred to?

Dr. Baganz. That would be if you had patient care activity in building 43. Because of the weather you should not have only outside communication. You would have to have some internal connection for weather in that climate.

Mr. Steinberg. And the cost of such a tunnel in and of itself would render that prohibitive in terms of cost?

Mr. Cralle. An enclosed causeway is perhaps better.

Dr. Baganz. The cost is not the issue. It would be programmatically fragmented medical care. The cost of the tunnel of the enclosed walkway is not desirable at that distance, but many of our nursing homes are connected in similar fashion and there is no policy to have an interconnected or nonconnected or within the hospital shell or not.

Mr. Steinberg. But is it programmatically superior to have them as close as possible?

Dr. Baganz. The policy we have is, we do not build diagnostic support in the nursing home care units. We have such support in the hospital that is adjacent, so we have no X-ray, no lab or things of that sort.

Mr. Steinberg. So you at no point ever considered the nursing home being in building 43?

Dr. Baganz. The only one program that we considered that might be appropriate and was a compromise was psychiatry. That was not even all of psychiatry, it was outpatient and a part of inpatient psychiatry.

Mr. Steinberg. Did you ever consider the rest of nonpsychiatry outpatient being in building 43?

Dr. Baganz. Programmatically this would not work.

Mr. Steinberg. That is confusing since you presently have the outpatient facilities totally separate and by a much larger geographic difference. Isn't that right?

Mr. Cooney. Yes, we do have a separate outpatient clinic. And that is one of the motivating forces for new construction, is to consolidate that program.

It is the opinion of our medical staff that the consolidation of inpatient and outpatient care is the ultimate in quality of care and we use our staff interchangeably. We want the same physicians treating the patients on an inpatient, outpatient basis. So one of the goals is to draw that separate clinic into the main hospital complex for that very purpose.

Mr. Steinberg. Do you have some basic questions as to the effectiveness of the arrangement you have right now?

Mr. Cooney. I certainly do. And it is certainly not cost effective because we have to duplicate many of our facilities.

Mr. Steinberg. Is there a problem in getting the continuity of care that you want with geographically-separated facility like that?

Mr. Cooney. Yes there is.

Mr. Steinberg. Why was the decision made then to raise those problems as to the service-connected population and to have the non-service-connected outpatient care rendered within what you have described to be a more attractive and effective programmatic arrangement; that is, inpatient and outpatient in the same facility?

Mr. Cooney. That clinic was originally for the service-connected; operating clinics were connected with the original office and were not part of the hospital system.

Mr. Steinberg. Originally there was no outpatient care except for service-connected care?

Mr. Cooney. That clinic was located in those buildings away from the hospital. The hospital was not responsible for the care of those patients evidently. As the workload increased at the hospital there was no space to bring those clinics into the main structure of the hospital. We have integrated many of our service-connected outpatient clinics into the main hospital, particularly our general medical clinic. Most of our specialty surgical clinics are now integrated into the hospital.

We just do not have adequate space to consolidate any more functions from that clinic.

Mr. Steinberg. If that particular clinic does not take care of the total service-connected demand for outpatient care, what proportion of it does it take care of?

Mr. Cooney. I couldn't tell you offhand. We have our mental hygiene clinic, our day treatment center, our comp and pension exams are being done there.

Mr. Steinberg. You do not have comparable facilities, that is, a mental hygiene clinic or day hospital, at the outpatient facility at the hospital?

Mr. Cooney. No, we don't.

Mr. Steinberg. You only have those at the service-connected unit?

Mr. Cooney. Yes.

Mr. Steinberg. There is no duplication of services in terms of types of care between those two facilities?

Mr. Cooney. Not in those particular areas.

Mr. Steinberg. In any area?

Mr. Cooney. No, I would think not.

Mr. Steinberg. Do the veterans' repreesntatives from the Minnesota area have any concern about that configuration at present? Has that worked reasonably well as far as the service-connected and non-service-connected population is concerned?

Mr. O'Neill. Mr. Steinberg, I'm John O'Neill with the Veterans of Foreign Wars. The reports that we have from the veterans that have been going to the outpatient clinic, the building itself is so old that a disabled veteran having a problem walking even has a problem in the building. If a patient requires hospitalization, I think there is about a mile difference, to get them over to the hospital. And the people that we have that go over there, that is the biggest complaint—the distance between the two.

And there is another problem with bus service. There is no decent bus service between the outpatient clinic and the hospital.

Mr. **Steinberg.** The VA does not run its own bus service for that?

Mr. **O'Neill.** No, I don't think so. It's just metropolitan transit.

Mr. **Cooney.** We do have a shuttle bus that transports patients back and forth between those two corridors.

Mr. **Steinberg.** Which is kept secret from the Veterans of Foreign Wars?

Mr. **Cooney.** Not intentionally.

Mr. **Steinberg.** Mr. Ohnstad, do you have any comment on that?

Mr. **Ohnstad.** I think the geographic separation certainly does present problems.

Mr. **Steinberg.** Do you have any comments on the service-connected versus the non-service-connected nature of the clinics?

Mr. **Ohnstad.** I don't understand what you are asking.

Mr. **Steinberg.** The Fort Snelling outpatient clinic, which is by all accounts a far less desirable place both in terms of its own antiquity as well as its separation from the main hospital, is only for the service-connected veteran. The non-service-connected veteran gets his care at what would seem to be better facilities, and more geographically compatible facilities. It seems like a strange cut to make if one is making a cut as to who was to get the better facilities.

I'm wondering if you have any concern from that standpoint?

Mr. **Ohnstad.** I'm sure we would have a concern. I guess we're in a position that we simply have to utilize what is available to us at that point, and that is as far as I can make a comment on it.

Mr. **Heilman.** I have had some conversations with our national service offices in Minneapolis, and they did note the separation of the service-connected facility and that if, in fact, there were one centralized outpatient clinic for both service-connected and non-service-connected, it would be much easier in terms of the services that that office renders. I did not receive any specific complaint about the quality of care, of outpatient care, that the service-connected care was inferior because of the separate facility.

Mr. **Steinberg.** Would you speak to your service officers again and see whether there are any problems in that regard? Obviously this particular configuration is going to go on for quite some time in the future. The new facility would be completed on what date?

Mr. **Cralle.** 1987.

Mr. **Steinberg.** So, if there are concerns about that, it would be wise that we be apprised of them at this point. You also heard Mr. Cooney's description of the kinds of services that generally are provided at that separate outpatient facility and that many services are provided for service-connected veterans at the so-called non-service-connected outpatient clinic. If you would get comments on that, that would be helpful.

Mr. **Schwab.** I have a question, if I may, for the record. I believe Dr. Hanson brought up the cost effectiveness and it alludes me at the moment in what context, but it is my understanding the Veterans' Administration treats inpatients at considerably fewer dollars per day than community hospitals. I wonder if we could have a statement from the VA in this regard.

Mr. **Steinberg.** Herb, do you want to respond to that?

Dr. Baganz. I can't speak specifically to Minneapolis. The reason for this is it is a very difficult methodology to make such cost comparisons due to many variables but where there has been a methodology developed for and applied to short-term medicine and short-term surgery episodes of care, the VA compared to the same care in community hospitals, was 7½ percent cheaper in 1978.

Mr. Steinberg. That is based on the revision of the study that was done several years ago?

Dr. Baganz. There are still some great difficulties in the assumptions. We are currently working on a new methodology to make a valid diagnostic related type of comparison. We have had to work with episodes of care rather than per diem costs.

Mr. Steinberg. That is down from 10 percent from the time it was originally estimated?

Dr. Baganz. It is 1 percent less than the prior study.

Mr. Steinberg. Was that the study that the NAS offered reservations about and you undertook a revision, and you say that you have a further revision in process?

Dr. Baganz. No. We're not doing a further revision. We're developing an improved methodology for cost comparison.

Mr. Steinberg. What is the timetable for that?

Mr. Baganz. That will be done some time in September 1981.

Mr. Steinberg. Did you have anything further on that issue?

[No response.]

Mr. Steinberg. What I would like to do is take a 2- or 3-minute break and then give each of you a brief opportunity to add some points or to ask some questions concerning points that have or have not been raised. So we will break until about 36 after.

[Whereupon, a brief recess was taken.]

Mr. Steinberg. We'll resume now.

One issue, before we open it up a little more broadly, that we have not focused on, to clarify our understanding, is the cost of equipping the facilities. I don't know if the community is aware of this, but the VA has estimated in a document it has given to us as part of its Public Law 96–22 prospectus, that the equipment cost for the facility would be $43.2 million over and above the $221.4 million. So we're talking there about a total cost of $264.6 million in terms of a finished structure.

Do you have an idea, Mr. Dickler, of what the comparable equipment costs would be for your facility?

Mr. Dickler. Mr. Steinberg, I believe we have an estimate in our current budget for equipment of approximately $24 million. But I should add that that presumes a certain amount of equipment purchased between now and the completion of that project, and not withholding those purchases until the project is completed and buying all of the equipment at that time.

Mr. Steinberg. Does the VA projection of $43.2 million also include gradual acquisition, or is it all being purchased in 1987?

Dr. Baganz. I can't speak to that, as to just what is in that equipment list.

Mr. Steinberg. Is there anyone that can speak to what is in the equipment list? Is the cyclotron included in that?

Mr. Martin. No, sir. The cyclotron is not in at the present time, and we have not inventoried existing equipment. There is a lot of sophisticated equipment that would still be in usable condition at that time. I think the biggest thing is that people fail to recognize the fact that we are still extremely early in the planning process. We are not even to an improved conceptual plan at this time.

We have not gone into detail on any equipment at this time, and it could vary a great deal.

Mr. Steinberg. Could you give us an estimate for the record as soon as possible of what the equipment cost would have been for the replacement with renovation option? One would assume that it would not have been the same amount.

Mr. Cralle. I think it would be substantially the same.

Dr. Baganz. The equipment is movable equipment. It's not part of the installation or construction of the building.

Mr. Martin. Fixed equipment is in the construction.

Mr. Steinberg. You say that the $43.2 million figure does not take into account the salvaging of any existing equipment at the medical center?

Mr. Martin. It would be reduced.

Mr. Steinberg. It does not take that into account. The $43.2 million figure is for a total new acquisition?

Mr. Martin. Yes.

Mr. Cooney. I would assume that that would be a total equipment——

Dr. Baganz. Do you know what the inventory of the current equipment at that facility is?

Mr. Cooney. No.

Dr. Baganz. It all has a useful life and it is all worked out by new and replacement equipment basis that is in our budget as a separate line item. So it would be based on that same methodology and logic. I can't explain it.

Mr. Steinberg. If you had to equip the Minneapolis hospital, given your present budget request, you probably couldn't purchase any other equipment if you were doing it in fiscal year 1981, is that correct?

Dr. Baganz. Basically, as you are aware, in our presentation there is no new special medical service, there is no new program, there are no new beds in the proposed construction, other than 120 nursing beds. So the only new equipment that is nonexistent that would not have to be replaced due to the state-of-the-art technology, would be those in the nursing home care unit.

Now, as to what kind of equipment you would move into a new facility and whether it meets the state-of-the-art and whether it is worth the expense of taking it down and moving it versus buying it new, that is in the methodology arrived at in the prospectus, and I am not the person that prepared that. But we can find out where those figures come from, if you would like.

Mr. Steinberg. And you can also find out some rough estimate as to how that figure would be reduced as a result of salvaging existing equipment?

Dr. Baganz. I would tend to think that would be later on in the process.

Mr. **Steinberg.** The equipment might not be salvageable 5 years from now.

Dr. **Baganz.** Or it might not be technically appropriate to continue a useful life. It may be the state-of-the-art is such that it is better to replace it.

Mr. **Steinberg.** We would appreciate whatever additional information you can give us on it. I'd like to suggest to Mr. Coy, that for the future, in terms of the line item prospectus that we get, it would be helpful if you could provide a little bit more information than just a gross dollar figure which turns out to be a total replacement cost.

It may turn out to be the most realistic estimate, but if we could have a little bit more information on how it was composed, that would be helpful.

[Subsequently, the Veterans' Administration furnished the following information:]

Current data shows that each replacement hospital bed requires $36,000 worth of support equipment. This is a total figure representing laboratory, radiology, dietetic, furnishings, medical and surgical instrumentation and basic personal property items. In the projected 725-bed Minneapolis replacement hospital this equates of $26M. For a nursing home care unit bed the equipment cost figure is $28,000; therefore, the 120-bed Minneapolis NHCU would require $3.4M in new equipment. These items represent major equipment which will be state-of-the-art and the most effective and efficient equipment to meet the tertiary care mission assigned Minneapolis. The life expectancies on equipment in the present hospital will be extended wherever possible to assure that the major equipment purchased for the replacement hospital will truly be necessary and the most economical alternative.

During the construction years of the replacement hospital certain equipment will need to be replaced. These items will be required regardless of the decision to replace or remodel and comprise an additional component to the equipment costs. The estimated replacement of equipment costs during the construction years are as follows:

Fiscal year:	*Cost (in millions of dollars)*
1981	$1.5
1982	2.7
1983	1.7
1984	1.5
1985	2.6
Total	10.0

The total estimated equipment cost for the replacement hospital and nursing home project is:

	In millions
Hospital	$26.0
Nursing home	3.4
Replacement over 5 years	10.0
Total	39.4

We are also expecting to replace approximately $1.6 million worth of equipment during fiscal year 1980 which further contributes to the equipment costs.

Mr. **Steinberg.** The cyclotron would be new equipment for a new service. What is the status of that in your present planning?

Mr. **Martin.** At the present time it is a recommended special medical program, and it would involve extensively the sharing of this service with Twin City Hospitals and Greater Regional Hospitals.

Mr. **Steinberg.** What is the cost?

Mr. Martin. The cost of the cyclotron today would be, with the position, about $5.5 million.

Mr. Steinberg. That is just the equipment. Does the university have its own cyclotron?

Mr. Martin. No. Very few people have them.

Mr. Steinberg. Why wouldn't the university be purchasing it?

Mr. Martin. This is something we're talking about from the standpoint of sharing.

Mr. Steinberg. They would be sharing that with you, is that what you're saying?

Mr. Martin. Yes.

Mr. Steinberg. Why don't we go around the room, starting this way, if we could, with Mr. Miller, who is the commissioner of the department of veterans affairs in the State, and see if he has any brief observations or any questions that he would like to pose to any of the participants.

Mr. Miller. Mr. Steinberg, I am happy that I had the opportunity to be with you at this particular hearing. What I would get into would be the concept of the care of the veteran, and I believe just about everybody in this room is very much aware we feel that the people of the United States have this responsibility and certainly I'm going to do all I can to see that the veterans in our particular part of the country do, indeed, have the best possible medical care.

I regret that we are starting to get into some community-oriented problems of overbuilding, of perhaps some sharing, correcting somebody else's mistakes. I don't think this fits in the veterans program and therefore I would hope we could proceed with this new construction with the proper equipment to care for our veterans in the north-central part of the country.

Thank you.

Mr. Ohnstad. I would like to make a comment. From the point of view of those of us who are the consumers of medical care, we are certainly supportive of the new facility, and we hope that it can in fact be built.

Mr. Steinberg. Does the VFW have anything to add?

Mr. Schwab. I have said all I have to say. Do you have anything more?

Mr. O'Neill. My only point would be, I'm an administrative function and not too much into the service function as the service officers are, but despite that fact, I don't think that 2 days go by that I don't get a call wanting to know, how can I get into the VA hospital. And if the VA hospital isn't replaced within a certain period of time, how long would it be before it would be closed, because it wouldn't be a functional facility.

Mr. Heilman. I have nothing further, except to thank you for the invitation to attend today.

Mr. Steinberg. Let's start down here with Mr. Mitchell. Do you have some questions or are there some points that you think require some clarification at this point?

Mr. Mitchell. I guess the only question to me at this point is whether some of the information which you have received is available to us in the process that we are going through, or isn't it?

Mr. STEINBERG. I think I tried to insure that that is the case. What particular information are you raising questions about?

Mr. MITCHELL. I'm not sure whether we have received it or not.

Mr. STEINBERG. I believe you have the overview and informally have the master plan.

Mr. MITCHELL. Yes. The other one was something that you just mentioned in terms of equipment.

Mr. STEINBERG. We have a one-page document, and we'll be glad to share it with you. I think the sum total of it is the $43.2 million figure for equipment.

This was part of the official prospectus which the VA submitted, but I think you also heard that the figure is subject to a substantial amount of question.

You sent a letter to the VA in February requesting certain information which I understand started arriving around the end of March.

Mr. MITCHELL. Correct.

Mr. STEINBERG. At your March 26 meeting?

Mr. MITCHELL. Correct.

Mr. STEINBERG. Are you satisfied at this point that you are getting the requisite degree of cooperation in obtaining information that you need to make an enlightened recommendation in early May?

Mr. MITCHELL. As I indicated, I haven't had a chance to look at the document received yesterday. Subject to what is in that document as specifics, I think there are still possibly some gaps in information from what we asked for in February, and we would like to obtain that. But we recognize the VA, as I said, haven't had some of that information put together. The time frame that we have been operating on is a short one. We recognize the difficulty in putting together a lot of information which wasn't prepared in advance, so to speak, but I think we're comfortable with getting information. We would like to have as much as possible as early as possible, because given our time frame, the time is moving very quickly.

Mr. STEINBERG. What is the position of the agency with regard to answering the questions that they posed to you in their February letter? Who would like to speak to that?

Dr. BAGANZ. As I said earlier, we are very pleased to share information and to go through this review process. We have no authority to contract for a "certificate-of-need" process, although the information we have may not be in the same format as that used for the "certificate-of-need" under a review for the reimbursement kind of a system, we can supply the same basic information. With that caveat, we can supply any kind of workload data they need, however, it may not be in quite the cost center relationships that they are used to working with. I think we and they can bridge that problem.

Mr. Cooney has assigned two of his staff to work closely with him, and I don't really foresee any problem.

Mr. STEINBERG. Mr. Cooney, you have a February 25 letter I believe.

Mr. COONEY. Yes; I do.

Mr. STEINBERG. Would you please provide us, as soon as possible—and you can do it by annotating the attachments—the places where you have provided data, the places where you have not provided data but will provide it in time for their review, and the places where you do not have the data readily available. And in those areas where the data is not available, please explain why. We would like the record to be clear as to the extent of the agency's cooperation with the local planning process.

[Subsequently, the Veterans' Administration furnished the following information:]

The attached copy of the letter of February 25, 1980, from the Metropolitan Health Board as annotated represents the efforts of the Veterans Administration to provide the necessary information.

METROPOLITAN HEALTH BOARD,
St. Paul, Minn., February 25, 1980.

Mr. DANIEL COONEY,
Administrator, Veterans' Administration Hospital,
Minneapolis, Minn.

DEAR MR. COONEY: Thank you for your recent letter to the Chair of the Metropolitan Health Board indicating the willingness of the Minneapolis Hospital to undergo review of the proposed replacement of the hospital. This replacement project will have a significant impact on health resources and services available to veterans in this Region and we look forward to examining that need with you. In addition, this review will serve to enhance and complement the voluntary hospital long-range planning process occurring in the Metropolitan Area.

In a separate letter to Dr. Baganz of the VA in Washington, we have noted that while review of the VA project would occur pursuant to the Intergovernmental Cooperation Act of 1968 and OMB Circular A-95, it is our intent to use a process similar in nature to the process used to review Certificate of Need applications from other community hospitals. Therefore, we have requested that an agreement be developed which would allow for a time frame and analysis commensurate with the scope of the proposal but in as timely a manner as possible.

In order to begin the review process, it is requested that additional information be submitted to the Health Board to enable review. We would be looking at essentially four major areas. They are:

The role and relationship of the hospital in the VA system and with the local community;

The need for the hospital in terms of demographic data and other statistical information;

The fiscal and economic impact of the replacement; and

The relationship between the local VA Hospital and the University of Minnesota in terms of co-location, medical education programs, medical staff and specialty services.

Enclosed is a list of the type of information that should be included in the document submitted for review.

We appreciate the cooperative spirit of the VA in undergoing this review. It can only help to further the efforts of the provider and consumer communities in this area to ensure that the best health care resources are available at the most reasonable cost. Let me offer the full assistance of the Health Board staff to you in assembling the necessary information for review of the project. If any of us can be of help, please do not hesitate to call me or John Hurley.

Sincerely,

MALCOLM P. MITCHELL,
Executive Director.

Enclosure.

DESCRIPTION OF INFORMATION TO BE PROVIDED TO THE METROPOLITAN HEALTH BOARD FOR THE VA HOSPITAL

The proposed replacement of the Minneapolis VA Hospital and the construction of the chronic care facility has a substantial impact on the hospital and health care services in the Metropolitan Area and the upper midwest. The review of the proposed facility and services will be based on eventually four major areas. They are: The role and relationship of the hospital in the VA system and with the local community; the need for the hospital in terms of demographic data and other statistical information; the fiscal and economic impact of the replacement; and the relationship between the local VA Hospital and the University of Minnesota in terms of co-location, medical education programs, medical staff and specialty services.

To provide the information necessary for the review, the following listing of information is requested to permit an understanding of the project, its impact on the health care system, and the planning for an integrated system. In every instance, additional information which is felt to provide further clarification or elaboration should be provided.

The information needed by the Health Board of the Metropolitan Council to review the proposed replacement of the VA Hospital could follow the format required of local community hospitals that require Certificates of Need. An application form is enclosed which would provide guidance in completing the necessary information.

	Date furnished to HSA
A. Description of the proposed project:	
1. Describe any buildings to be constructed, any physical plant modifications of an existing structure, the age of the existing structures and all manners in which it does not conform with health survey standards.	Apr. 8, 1980.
2. Describe all health services to be provided or modified by the proposed projects.	Apr. 2, 1980.
3. Describe the proposed use of any facility and service space which will be replaced by the proposed project.	Apr. 8, 1980.
4. Describe the present and proposed gross and net square feet by department or functional area.	Do.
B. Role and relationship:	
1. Describe the role of the proposed VA hospital and chronic care facility within the context of the VA hospital system in the United States.	Apr. 2, 1980.
2. Describe the role of the Minneapolis VA Hospital in relationship to other VA hospitals and other chronic care facilities in Minneapolis, North and South Dakota, Iowa, and Wisconsin.	Do.
3. Describe the relationship between the Minneapolis VA Hospital and the State of Minnesota's health care facilities for veterans.	Do.
4. Describe the changes, if any, in the role of the hospital that will occur because of its replacement.	Do.
5. Describe the service area of the present and proposed Minneapolis VA Hospital and chronic care facility.	Do.
a. Describe the methodology used to define the service area.	Do.
b. Describe the present veteran population in this service area.	Do.
c. Describe the projected veteran population in the defined service area for the next 20 years in 5 year increments and the methodology for making the projections.	Do.
d. Describe the projected population by age cohorts for the population referred to in 5b and 5c above.	Do.
C. Need for the facilities and services:	
1. Provide the origin of inpatients for both admissions and patient days of service category (medicine, surgery, psychiatric, rehabilitation, chemical dependency) for all patients discharged during the years 1974, 1976, and 1978. The origin should be provided by county for Minnesota residents and by State for others.	Apr. 2, 1980, 1976–78 only.

C. Need for the facilities and services—Continued

	Date furnished to HSA
2. Provide a 1-month sample of all patients discharged during November 1978 using the data collection methodology of the Metropolitan Health Board's 1978 Hospital Patient Origin Survey (a sample form is attached).	Apr. 2, 1980.
3. Provide utilization statistics for each of the last 10 years including the following:	Do.
a. Provide the total possible bed capacity of the present hospital for each of the last 10 years by service category.	Do.
b. Provide the total staffed and operated bed capacity of the present hospital for each of the last 10 years by service category.	Do.
c. Describe the number of private rooms, semiprivate rooms and wards and the number of beds in each ward for both the total capacity and presently staffed and operated capacity.	Do.
d. Provide the patient days by major category of service for each of the last 10 years.	Do.
e. Provide the occupancy rates for both the total bed capacity and operating bed capacity by major category of service for each of the last 10 years.	Do.
f. Provide the average length of stay by major category of service for each of the last 10 years. Also, provide the average length of stay by the major discharge diagnosis which constitutes the majority of patient days in each service.	Do.
g. Provide the admissions by major service category for each of the last 10 years.	Do.
h. Provide age-specific projections of service utilization for a through g above for the next 20 years. Provide a description of the assumption and methodology used to make these projections.	Not available.
i. Provide the number of patient visits in the outpatient clinics by type of clinic and projections of use for the next 20 years.	Do.
j. Provide the number of procedures and patients for both inpatient and outpatient use of specialized service such as radiation therapy, CT Scanning, kidney dialysis, rehabilitation, etc. by service and projection of use for the next 20 years.	Apr. 2, 1980.
k. Provide the number of inpatient and outpatient surgical operations performed in each of the last 10 years and projections for the next 20 years.	Apr. 2, 1980, 10 years only.
l. Provide the number of laboratory procedures performed for inpatients and outpatients in each of the last 10 years, and projections for the next 20 years.	Do.
m. Provide the number of general radiology procedures performed for inpatients and outpatients in each of the last 10 years and projections for the next 20 years.	Do.
4. Describe the relationship of the proposed project to the HSP, AIP, and any other planning priorities established for the metropolitan area, Upper Midwest and the VA system.	Apr. 8, 1980.

	Date furnished to RH
D. Economic/fiscal impact:	
1. Describe in detail the total costs and breakdown of all capital expenditures contemplated for the completion of the project including: construction costs, fixtures and furnishings, equipment, and architects fees and contingencies.	**Apr. 8, 1980.**
2. Provide an estimate of the total annual operating costs for both inpatients and outpatients contemplated for each year through the fifth year after completion of the project inclusive of anticipated salary requirements of the staff according to: salaries, employee benefits, supplies, purchased services, maintenance, insurance, depreciation, interest (if applicable), and other (please specify).	**Do.**
3. Provide for comparison purposes the actual costs for each of the last 5 years according to the same expenses listed above.	**Do.**
4. Provide the full-time equivalents by hospital department for each of the last 5 years and for each year through the fifth year after completion of the project.	**Do.**
5. Describe all sources of revenue for both inpatients and outpatients by type of source, to meet the expenses described in 2, 3, and 4 above.	**Not applicable.**
6. Describe the manner in which the project will be financed to include the amount and sources of all funds, progress toward obtaining said funds and the cost per patient day, if any that will go toward repayment of those funds.	**Apr. 8, 1980.**
E. Relationship With the University of Minnesota:	
1. Describe any present relationships with the University of Minnesota Hospital and medical school for medical education and clinical programs.	**Apr. 2, 1980.**
2. Provide a listing by specialty of the medical staff at the VA, identifying members also on the staff of University Hospitals.	**Do.**
3. Describe the medical education programs for medical students, residents, and other health care students which are provided at the VA hospital.	**Do.**
4. Discuss the nature of the relationship of physicians who admit patients to the VA Hospital to the Medical School at the University of Minnesota.	**Do.**
5. Provide a description of all programs now operated at the VA or the University Hospitals which are shared.	**Do.**
6. Provide a description of any present and proposed referral arrangements for patients between the VA Hospital and University Hospitals, and an estimate of the number of patients which have been referred for the last 5 years.	**Do.** **Do.**
7. Discuss any future sharing arrangements between the University and the VA Hospitals and medical school.	**Apr. 2, 1980, discussed.**
8. Discuss any consideration past and present to colocate with the University of Minnesota Hospitals, describing the nature of those considerations and reasons for their success or failure.	**Do.**

SECTION 1: GEOGRAPHIC SERVICE AREA OF PROPOSAL (FOUR PARTS)

Include as attachment No. 1 a clear description of the geographic area to be served by the proposed project by (a) listing and specifying the portion (or total) of all counties, municipalities, towns or villages to be served, (b) estimating the

range of the service area by indicating in miles and geographic boundaries the distances served in all four directions from the actual physical site of the proposed facility, (c) providing a graphic identification of the geographical service area—labeling where feasible all communities composing the primary service area (where approximately 80-85 percent of the patients are known to or can be expected to originate from), (d) identifying all sources utilized in determining the service area of this project, e.g., patient origin data and local surveys.

SECTION 2: POPULATION OF THE SERVICE AREA (FIVE PARTS)

Include as attachment No. 2 a description of the population to be served by the proposed project by including the following: (a) the current population of each county, municipality, town or village included in the proposal's geographic service area, (b) the population of each of these governmental units as given in the preceding 1960 federal decennial census and also where reasonably available as projected for 1980, (c) a breakdown of the population by available age groupings which shall include the category 65 and over for each of the governmental divisions included above, and (d) an estimate of the total population to be served, (e) identification of all sources of figures given above.

SECTION 3: SAME OR SIMILAR HEALTH FACILITIES IN SERVICE AREA (ONE PART)

Include as attachment No. 3 the names and locations of all health care facilities offering the same or similar health care services to any portion of the area to be served by the proposed project. Note, any applicant proposing a health care facility project intended to serve substantially more than a local constituency shall be required to list only the names and locations of those institutions offering such services to the same constituency.

SECTION 4: DESCRIPTION OF THE PROPOSED PROJECT (EIGHT PARTS)

Include as attachment No. 4 a reasonably detailed description of the project. This description shall include by alphabetical letter and in the order given specific responses to each of the eight question-items listed below:

(a) A description of any building to be constructed; and any physical plant modification to be made on an existing structure: the age of existing structure and all manners in which it does not conform in accordance with public health modernization survey standards to include physical plant, services and number and types of beds in non-conformance.

(b) A description of the number and types of beds to be added; and if the project involves modification of any existing health care facility, the bed complement of the existing institution to include, in the case of nursing homes, the number and types of beds currently provided.

(c) A description of all health services to be provided or modified by the proposed project.

(d) A description of the number and kinds of new staff positions to be created by the proposed project, and basis for anticipation of the successful recruitment of these new personnel.

(e) An approximate total and breakdown of all capital expenditures contemplated for the completion of the project.

(f) An estimate of the total annual operating costs contemplated upon completion of the project, inclusive of anticipated salary requirements of new staff.

(g) The occupancy rates for an existing health care facility submitting a construction or modification proposal to include rates for (A) each of the preceding twelve (12) months, (B) each of the past five (5) years, and (C) a five (5) year total average occupancy rate.

(h) An indication of anticipated occupancy rates of a health care facility for the first, second, and third years of operation after completion of the project (required only for proposals involving the addition of beds).

SECTION 5: EFFECTS OF THE PROPOSAL ON PATIENT COSTS (THREE PARTS)

Include as attachment No. 5 (a) Description of the anticipated effect of the proposal in the average rates per day charged by an existing facility to include a statement of the current rates per day charged patients. (b) Nursing homes shall indicate, additionally, the proportion of their residents who are welfare recipients and any differences in their rates from those of private paying patients. (c) Where a health care facility does not already exist, an indication of the approximate rates per day expected to be charged patients shall be given.

SECTION 6: IMPACT OF PROPOSAL ON OTHER HEALTH FACILITIES IN AREA (THREE PARTS)

Include as attachment No. 6 (a) a clear indication of the amount of service area overlap of the proposed project with each of the institutions mentioned in Item 3 of this Application Form, (b) and where such information is reasonably available the recent occupancy rates of those institutions, together with (c) a description of the probable effect of this project on the occupancy rates of each.

SECTION 7: NEED FOR THE DEVELOPMENT OF THE PROPOSED PROJECT (THREE PARTS)

Include as attachment No. 7 in a systematic and reasonably complete fashion:

(a) all pertinent data, information, and findings collected by the applicant which establish actual need for all aspects of the proposed project—by the population of the service area and all other possible grounds for this undertaking;

(b) letters of support from health care providers, public and private agencies (including county welfare departments for nursing home and boarding care home projects) in the communities affected by the project;

(c) the methods, formulae or rationale that were utilized to determine the exact number and type of additional beds provided for in this proposal and for determining the proposed nature and scope of any extension or expansion of services.

NOTE: All sources of figures given above should be clearly identified and references to waiting lists documented.

It is reminded that the burden of proof for justifying the need for and desirability of a proposed project rests upon the applicant. This section is therefore of particular importance and will be given much serious attention.

SECTION 8: RELATIONSHIP TO ANY ESTABLISHED PLANNING PRIORITIES FOR THE AREA (ONE PART)

Include as attachment No. 8, where such information is reasonably available, indication of the relationship of the project to any planning priorities established for the area to be served.

SECTION 9: METHODS OF FINANCING (FOUR PARTS)

Include as attachment No. 9 a description of the manner in which the project will be financed to include (a) the amount and sources of all loans, (b) indication of ability to obtain said loans, (c) the amount of current indebtedness, and (d) the cost per patient day that will go toward amortization of all indebtedness after completion of this project.

SECTION 10: ANTICIPATED COMMENCEMENT AND COMPLETION DATES (TWO PARTS)

Include as attachment No. 10 (a) a statement of the anticipated dates for commencement and completion of the proposed project, and (b) the basis on which these dates are given.

VETERANS' ADMINISTRATION,
DEPARTMENT OF MEDICINE AND SURGERY,
Washington, D.C., April 15, 1980.

Mr. JOHN HURLEY,
Senior Planner, Metropolitan Health Board, Metro Square Building, St. Paul, Minn.

DEAR MR. HURLEY: I am pleased to find that a number of your concerns as originally expressed, relevant to a data base pertaining to the replacement of the Minneapolis VAMC, are well on their way to being resolved. We encourage and appreciate having the State Clearinghouses and their planning groups review our major construction projects, such as the Minneapolis VAMC under the OMB A-95 process and the Intergovernmental Cooperation Act of 1968.

I trust the meeting that was held by Mr. Steinberg on April 8, 1980, and the input from the Department of Medicine and Surgery of the VA was helpful to you in understanding our mission and those requirements that are mandated by law. Perhaps you can better appreciate why it is very difficult for us to even consider buying care for our veterans in facilities external to the VA.

I trust also that the data that was provided to you prior to that meeting will be of assistance. I am certain you will recognize that the data bank of the Veterans Administration is very extensive and unlike the private sector where this type of data is used to support the reimbursement system, within the VA it is primarily used as a management and reporting tool.

I have been assured that Mr. Cooney will continue working very closely with you as the representative of the Department of Medicine and Surgery.

Sincerely,

HERBERT M. BAGANZ, M.D.,
Assistant Chief Medical Director
for Planning and Program Development.

METROPOLITAN HEALTH BOARD,
St. Paul, Minn., April 7, 1980.

HERBERT M. BAGANZ, M.D.,
Assistant Chief Medical Director for Planning and Program Development, Department of Medicine and Surgery, Veterans Administration, Washington, D.C.

DEAR MR. BAGANZ: Thank you for your recent letter summarizing the position of the Department of Medicine and Surgery on our letter of February 22, 1980. In a separate letter to Mr. Cooney dated February 25, 1980, we outlined the nature of the information the Metropolitan Health Board would need to make an analysis commensurate with the scope of the proposed new VA hospital in Minneapolis. A copy of that letter was sent to you. That letter to Mr. Cooney also mentioned the February 22 letter to you and its request that an agreement be developed which would allow for an adequate time frame for review and for sufficient information to perform such a review.

While you state in your letter of March 31st that the central VA is not permitted by law to enter into such a formal agreement, it is the position of the VA to have its local hospitals make every effort to cooperate with HSA requests. Further, you also stated that it is the intent of the central office to provide the Metropolitan Health Board with a profile of the planning process and all relevant data pertaining to the Minneapolis hospital and its proposed $221,400,000 replacement project prior to April 8, 1980. Such data, when complete, should be sufficient for the Health Board to perform its review. Inasmuch as the review time frame for both of us has been moved forward, there is no need to develop an agreement or consensus on that matter. We are assuming from your recent letter that the VA system will make every effort to cooperate in providing an application for the information requested in the 2/25/80 letter to Mr. Cooney.

Mr. STEINBERG. Mr. Mitchell, is there any other point or concern you would like to raise?

Mr. MITCHELL. Only that I think as we move forward in the process we will be making some suggestions and we would want to submit those to you and to the committee for your consideration.

Mr. STEINBERG. We would very much like to have them.

Mr. MITCHELL. Just a technical point, I guess. We have not ever, in a sense, received what we would consider a formal application for the review. We received the initial letter, and then a letter of information on a gradual basis.

Mr. STEINBERG. You have received it as formally as you are going to. I think that is clear.

Mr. Dickler, do you have any comments or questions?

Mr. DICKLER. Just a brief generic comment. The subject of sharing has been brought up several times during this afternoon's discussion, and there are a lot of factors that have to go into a consideration of sharing between Veterans' Administration hospitals and any other institution, and I think we are all aware of looking at the health-care delivery implications the overall size of the institution, it's comprehensive delivery program, and so on.

There is another factor, though, that I would like the committee staff and the committee to be aware of, and that is even if all parties agree that sharing is an appropriate thing to do, there exists certain barriers to doing the sharing. Among those are barriers within the Federal Government. A specific example would be that medicare has a regulation which prohibits their paying for patient care provided at a Veterans' Administration hospital if they are referred by another hospital for other than diagnostic procedures.

I mentioned earlier that we share stereotaxic surgery facilities. However, when patients are covered by medicare they must be informed prior to going into the Veterans' Administration hospital tha they will have to pay the cost of that out of their own pocket.

Mr. Steinberg. These are nonveterans?

Mr. Dickler. Yes. And medicare will not pay those costs becaus the care is provided in the veterans hospital.

There is also the obvious problems of merging Federal and no Federal governmental agencies and bureaucracies and all of the r quirements that are in there. They are real concerns in developin sharing and I did want to make a comment on them so people don make assumptions. Once the concept has been agreed to, is it in fa feasible to do so.

Mr. Steinberg. I take it that neither of your cost estimates at th point take into account whatever economies might be forthcomin through sharing?

Mr. Dickler. Ours does not.

Mr. Steinberg. Does the Veterans' Administration's?

Mr. Martin. Not at this point.

Mr. Steinberg. Do you view the economies of sharing in this sit tion, if any, in terms of costs after capital investment, that is co for salaries, and so forth? Is that the time when those economies more apt to occur? With the cyclotron, it's clear that there would capital costs that would be saved. But the chances that you would h two cyclotrons in the community would be very rare anyway, I t it. With reference to other sharing savings are we talking about ca tal investments that can be saved in terms of sharing, or are we ta ing about savings after both facilities are functioning?

Mr. Dickler. Personally, I would speculate that except for spe instances such as cyclotrons and other capital-intensive areas, would generally not realize any major cost savings other than which may be realized through ongoing operation of that service

Mr. Steinberg. Largely you see it after the facilities constructed?

Mr. Dickler. For the most part that would be our perspective.

Mr. Steinberg. George, the GAO has issued a number of repor the sharing area, some of them sharing within the Federal sector, others sharing between the Federal sector and the private secto would be helpful to us to have the individuals who were involved in writing that report give us any feedback concerning this particular discussion.

Mr. Peck. All right.

[Subsequently the General Accounting Office submitted the following information:]

Over the past several years, GAO has issued a series of reports regarding the sharing of medical resources among Federal agencies. These reports have focused on the direct health care systems of the Department of Defense, the Veterans Administration, and the Department of Health and Human Services' Public Health Service.

For the most part, the GAO reports have identified opportunities for sharing resources among Federal providers. The following major reports on opportunities for interagency sharing of Federal medical resources have been issued: "Sharing Cardiac Catheterization Services: A Way to Improve Patient Care and Reduce Costs" (HRD-78-14, Nov. 17, 1977); "Computed Tomography Scanners: Opportunity for Coordinated Federal Planning Before Substantial Acquisitions" (HRD-78-41, Jan. 30, 1978); and "Federal Hospitals Could Improve Certain Cancer Treatment Capability by Sharing" (HRD-79-42, Feb. 7, 1979).

In addition, GAO has issued a report based on visits to 50 Federal health care facilities which categorizes obstacles to interagency sharing and recommends specific actions to eliminate these obstacles. The report is entitled "Legislation Needed to Encourage Better Use of Federal Medical Resources and Remove Obstacles to Interagency Sharing" (HRD-78-54, June 14, 1978). This report is being used extensively by the VA in its role on the Federal Health Resources Sharing Committee to attempt to implement a more effective sharing program among Federal providers.

No GAO report has addressed the type of barriers described in the recent oversight hearings before the Senate Veterans' Affairs Committee.

Mr. Coy. I might add, Mr. Steinberg, that the barrier that the gentleman just referred to was actually somewhat eased by Public Law 94-581. Title 38 U.S.C. section 5053 specifically provides that medicare reimbursement can be received pursuant to services provided to a noneligible veteran under a sharing contract.

Mr. Steinberg. I think it would be helpful, Bob, if you would correspond with Mr. Dickler specifically about that so that they could have more than a verbal statement. Would there be any problem with that?

Mr. Coy. No.

Mr. Steinberg. Would it be preferable for them to give you a letter? I think it would be helpful to have that clarified.

Mr. Dickler. Very.

Mr. Steinberg. Ms. Kiehne, do you want to add anything?

Ms. Kiehne. I just have one comment. I would like to also thank you for the opportunity to be here, and on behalf of the Council of Community Hospitals, I would like to keep the communication lines open with the various veterans groups within the metropolitan area and see if we can't resolve some of the differences.

I do have one question, or it might turn into a series of questions. The first is, do you provide Ob/Gyn services presently at the VA hospitals for women veterans who might be of child-bearing age?

Dr. Petzel. We provide some limited services at the hospital. And anything else that is required, we get fee for service.

Ms. Kiehne. You give women vouchers to use services in other institutions?

Dr. PETZEL. The hospital would bill us directly if there was a woman eligible to have their benefits paid for. Not obstetrics, just Gyn.

Ms. KIEHNE. Is that a very big service?

Dr. PETZEL. No; it's not.

Ms. KIEHNE. Would there be room in the new facility for something like that?

Dr. PETZEL. We would plan on doing it similarly to the way we're doing it now.

Ms. KIEHNE. That's all.

Mr. STEINBERG. Dr. Hanson.

Dr. HANSON. I would like to make a few personal comments as an individual who has lived in the community for over 35 years, and has, I think, a perception of some of the developments that are taking place in the community. I am a Vietnam veteran. I have been exposed, to "Agent Orange." I have also trained at both of the hospitals, the university and the veterans hospitals. I have also taught at both of the facilities, and I am currently on the clinical staff and have an academic appointment at the university. With this background I would like to make some comments as a physician who has been practicing 10 years in the community and who has actively been involved with health planning for 5 years in this Twin City area.

I think we have a few very unique things that are going on in this community. Large forces that many of us have a difficulty conceptualizing are operating. I would like to make three points.

First, the community health planning is going on in our community voluntarily in a very satisfactory way from many points of view. I think we were developing a sense of trust, a sense of respect for the various forces that are interested in the health planning process. We don't always agree, but we have trust and respect of various forces from the provider side and from the consumer side. I think it's healthy and has a prospect of being very positive for the health planning process in our community.

Second, we voluntarily joined our community-wide effort in quality control, and have included all of our facilities, or most of our community facilities in the PSRO process. That is going on and we are learning, we're growing, and we think that is an important aspect of not only our quality assessment in the community, but also our cost containment.

The third point, and the one that is much harder to get a handle on, is the area of community health-care organizations that are in a competitive environment in our cities. The whole State is being impacted, but primarily this is focused in the large population center of the Twin Cities area. We have large groups of physicians either practicing primarily in hospital organizations or in large groups at the university and large clinics. We have the Mayo Clinic in southern Minnesota, all of whom are competing for health care.

We now have nine HMO's in the State of Minnesota. Seven operating in the Twin Cities area, who are competing for patient care. They are competing on the basis of good quality care, cost control, and access to care. This environment is very healthy, we think. We are all learning by it, but we feel that it is important to involve all of our health-care institutions in the public discussions of the process of planning, of quality control, and of competition.

I close my comments with that point except to say in planning for veterans, we need to take into consideration the needs of the veterans and how those needs can best be met. Requiring a certificate-of-need review, I think, as an individual in the community, would give the community an understanding at least of what the needs are and how these can be met currently and in the future, as the community progresses.

Mr. STEINBERG. I think that is an appropriate and useful perspective to place on the process. I would point out that Congress has clearly made a judgment that the certificate-of-need function itself should not apply to the VA or to any other Federal health-care facility, although the A–95 process clearly does require that notification should take place at the earliest feasible time, and that Congress, to the extent that it has spoken to it, has placed VA representatives in nonvoting capacity on the HSA's and on the SHCC's and has indicated its policy viewpoint that when an HSA is requested as part of the A–95 process, to submit its views that it should do so.

Beyond that, however, it is clear that the Congress and the executive branch, the two major partners here in the Federal effort, reserve for themselves the right to make the judgment, as a matter of overall national policymaking, concerning the needs of eligible veterans for services. I'm certain that Congress wants the input on the needs of communities such as all of you here today have articulated, and that it will certainly take these kinds of considerations into account in reaching a judgment.

But the final decision will be a Federal decision and not a local decision. I think this has been useful and informative for all of us. We have stayed as close as we possibly could to our schedule.

I'd like to congratulate the reporter who has had quite a difficult time. I'm glad that she was able to have a suitable chair. This is sort of like theater in the round, I guess, and we're very grateful to you for bearing with us.

Mr. Cralle has indicated that he has one closing comment to make and we will let him have the last word.

Mr. CRALLE. I would like to thank the veterans organization today as consumer representatives organized to support our client population. They are both our critics and our supporters. We're delighted to have them in the supporting role today. I appreciate the community's expressions today. We want to be a responsible member of the community.

I would not like to have this particular construction project held hostage to proposed changes to the law. We must operate in the environment as it is today.

I would like to speak to one last item and that is building 43. I do not think it is in the interest of the veterans or the taxpayers to sink $30 or $35 million into upgrading a 25-year-old building and then having that building in the system almost until the time where it becomes a national historic place.

I think it is much better to invest in a new facility. We're going to construct that facility using the VA building system, that is with the use of interstitial space. This makes it very functional and makes the change that is inevitable available at a minimum cost. I would suspect that the new hospital in Minneapolis will eventually be built and that it will eventually serve 50 or 60 years.

I think it is much better to go to a single modern facility.

Thank you.

Mr. STEINBERG. I'm sure no one wants to raise the hostage situation here today, so I won't comment on that, but I don't know of anybody who wants anything held hostage at this particular point or would even contemplate that for this country.

We are grateful to all of you that have come from Minnesota, from the veterans organization here in town, from the VA central office, and from the hospital administration of the medical center.

These proceedings will be printed as an official committee document although somewhat down the road. All of you that participated today will be sent copies of these proceedings. We have asked the VA to submit some information for the record. Bob, it would be very helpful to us if we could have the information for the record within the 7 days. If there are problems with specific items that we have requested, would you let us know and give us an idea of how much delay there will be?

Mr. COY. Yes.

Mr. STEINBERG. Thank you all very much.

[Whereupon, at 4:15 pm., the staff inquiry was concluded.]

APPENDIX A

Metropolitan Health Board,
St. Paul, Minn., May 2, 1980.

Hon. Alan Cranston,
U.S. Senate, Russell Senate Office Building,
Washington, D.C.

Dear Senator Cranston: On April 30, 1980 the Metropolitan Health Board held a public hearing to obtain public comment and to act on the A-95 application of the Minneapolis Veterans Administration Medical Center to replace their present hospital. Enclosed for your review and action are the results of that public hearing and recommendations approved by the Metropolitan Health Board. The enclosed record includes the Board's report on the project containing findings of fact, conclusions, recommendations, as well as the data analysis substantiating the recommendations; a set of exhibits containing supplementary information and written testimony submitted at the hearing; and a summary of the public hearing.

Final action by the Metropolitan Council on the Health Board's hearing record is expected on May 9. Their recommendations will be forwarded immediately following.

This record is based on the results of an in-depth study of the application and information submitted by the Minneapolis VAMC and VA central office, as well as information gathered by the Board's staff. The record was prepared from the results of six public meetings by one of the Board's project review committees comprised of 10 Board members. This committee began its review with staff of the Minneapolis VAMC on March 26 and completed its study on April 28 and submitted its report to the Board for the April 30 public hearing. The review committee's meetings were well-attended by a variety of interested persons from throughout the region. The record was completed by the results and actions at the public hearing. Approximately 300 citizens attended the hearing and about 30 persons presented testimony.

The Board wishes to take note of an issue raised by some commenters at the hearing, which the Board was not able to adequately address during its review because of the tight review schedule. Several commenters suggested that the Congress and the Veterans Administration explore the feasibility of developing a voucher system to be used by veterans in receiving hospital care, particularly for non-service-connected disabilities and health problems. The point was made that veterans who live beyond the Metropolitan Area would have increased access and convenience to care if they were able to use their veterans' benefits in their local community hospitals through such a system. It was also expressed that a voucher system would increase the cost effectiveness principle and affect conditions for reducing undue energy use due to the distances traveled by many outstate and out-of-state veterans. The testimony indicated that this issue might be worthwhile to explore.

On behalf of the Board, I wish to express our appreciation for being given the opportunity to participate in the review process on the VAMC proposal. We particularly thank the staff of the Minneapolis VAMC for their cooperation and the information which they gathered and prepared to enable the Board to complete its review. We hope this record will be useful and of value to Congress, the Administration and the Veterans Administration as they proceed with this project.

If we can be of further assistance in any way, please feel free to call on us at any time.

Sincerely,

Coral Houle, *Chairperson.*

Summary of the Public Hearing on the V.A.

Coral Houle ; Mrs. Houle commenced the meeting at 5 p.m. She read the purpose of the hearing .

Daniel Cooney; Mr. Cooney is Director of the V.A. Medical Center, Mpls., MN and introduced Dr. Petzel Chief of Staff amd Stan Bednar to the Board. Mr. Cooney provided an overview of the V.A. noting that it is a 737 bed hospital providing services in its primary service area and serves as a teriary service hospital for its medical district. 12% of its discharges are from its primary service area, 50% of its discharges are from within the 7 county Metropolitan area. He noted that the V.A. reduced by 124 beds in 1979. He described the space and functional deficiency study indicating the problems with the physical plant in the V.A. Building in Minneapolis. Mr. Cooney pointed out a number of factors on the description of the proposal that is contained in the report as well as in some of the Findings of Fact. He concluded by noting that it is the position of the V.A. that the GAO method is a scientifically developed method and that it shows 725 beds are needed and amy reduction in size would mean that care would be denied to eligible veterans.

Bob Christiansen; (Christiansen's testimony is included verbatum in the exhibits President, West Metro Trustees. Mr. Christiansen's testimony , included in the exhibits, the high points of his testimony are as follows: Strong opposition to the development of a health care facility independent of the local planning process regardless of whether it is a private or Federal facility. In our opinion, it is inappropriate for the Federal Government which developed a health planning process in the community to function outside that process for its own facilities.

Ted Kolderie , Mr. Kolderie's testimony is included verbatum . Mr. Kolderie raised the issue as follows: The question is whether we are sure that there should be a replacement. It is not an issue of whether the plant is antiquated or an issue of providing care to veterans. The issue is the way the V.A. delivers health care by owning and operating hospitalls. Mr. Kolderie raised the question of whether we could provide a demonstration in this state to test the idea whether the V.A. could deliver care in private community hospitals instead of building a new hospital. The primary method might be the use of a voucher system.

Janet Dieterich; Question Sounds as if you are critical of the staff report and its comments on the voucher system.

Kolderie; Yes, we are critical. We don't believe that the report analyzed the voucher system idea in detail.

Harry Lemieux; Mr. Lemieux's testimony is included verbatum. His primary points were as follows. He feels that this is a special interest hospital. It is a regional hospital. They have been decreasing beds, decreased from 862 to 738 in 1979. You are now asking them to give up another 116 beds. This is a akin to asking veterans to give up their benefits. Mr. Lemieux feels that more veterans would use the V.A. hospital if private insurers would pay for hospitalization. He feels that most Veterans prefer the V.A. Hospital.

O'Grady; Question: What do you think of the suggestion that the V.A. participate in a local planning process?

Lemieux; The V.A. has gone through the A-95 Review and if they have to go through a Certificate of Need, they would kiss this project goodby.

Mike Ohnstad: Mr. Ohnstad's testimony included verbatum and will not be repeated here.

O'Grady; Question: What do you perceive the unique needs of veterans, apart from those who had service connected disabilities, what are they:
Response:
Veterans with injuries in battle . Veterans who have problems because of agent orange . There are some health problem similarities between veterans and non-veterans but unique needs does not mean that they are not parallel health problems. In psychological areas there are conditions that might be related to being in battle, but are not service connected disabilities.

L. Poston; Dr. Poston's testimony is included verbatum, and his comments are summarized as follows: The VA is a valuable regional resource playing roles in education, clinical care and teaching. There is a quality issue. There are two separate systems for quality assurance and it is a concern of the medical association. The parallel systems do not allow consideration of comparison to community norms. The affiliation with the university could be strengthened through combination of these two systems. The Federal/local separation is an artificial one. The Certificate of Need process recognizes many inter-dependent relationships and Federal facilities should be part of that process. The affect on cost containment in this area would be hurt and we should ask Congress to reconsider this project. The size of the hospital will be a barrier to de-institutionalization of care for veterans. We would urge Congress to build a smaller facility and to provide legislation allowing care of veterans in community hospitals.

Stuart Hanson; Dr. Hanson's testimony is included verbatum, and his testimony can be summarized as follows: We feel the V.A. should be built at the Fort Snelling sight. It is a regional center and veterans have the right to choose the sight at which they receive their care. All patients should have quality care. However, the program should be coordinated with others for the purpose of cost efficiency. Our primary concern is the length of stay. V.A. hospitals are exempt from PS activity but have developed their own programs. We think that the V.A. should utilize the community resources. With respect to bed size, our position is that there ought to be a total of 513 beds excluding the nursing homes. We support the Health Board recommendation on consolidation of retal transplantation and radiation therapy. They should share any other services as much as possible. The recommendation for a smaller bed size hospital is not a retrenchment in our commitment to veterans, but offers community based choices to veterans for the highest level quality of care at the lowest cost.

O'Grady; Question: You mentioned other services for consolidation; what services would those be?

Hanson: Response: We have debated that but our task force is not ready to make any specific recommendations, but such services that would be looked at, of course.

would include open heart surgery and some specialty procedures in neuro-radiology and neuro-surgery.

John O'Neil; John O'Neil's testimony is included verbatum in the exhibits . He pointed out that the highest number of unemployed people is the Vietnam Veteran and also sighted the statistics in his hand-out indicating the veteran preference of the V.A. Hospital

Lyle Pearson ; Past National Commander, DAV. Mr. Pearson's testimony is as follows: Strongly supports the present sight and rejects any suggestion that the bed size be cut. Health board has overlooked the fact that the V.A. is a regional facility. Just because the Metro area is over-bedded and threatened with hospital cuts, the V.A. should not be burdened in attempting to solve that problem. Strongly resist any interference from outsiders. V.A. with all of its problems is still the only system that understands the unique needs of the veteran.

Joe O'Neil; Metro Trustee: Mr. O'Neil's points are as follows: 1) wondered why some money could not be saved by joint planning between the university and the V.A.,2) wondered whether it was appropriate for the V.A. to operate its own nursing beds, 3) the V.A. should submit its own long-range plan to the Health Board as other hospitals are expected to do.

Donald Miller; Commissioner of Veterans Affairs, State of Minnesota. Mr. Miller supported the 725 bed hospital noting that is was a marked reduction in hospital beds available to veterans from 20 years ago. He noted that 120 nursing home beds would aleviate the present problem of the hospital discharging patients who are not completely recovered. He noted further that the Minnesota Veterans Affairs Department has plans to build up to 1300 nursing home care beds. Presently they have 182 nursing home beds at the Minneapolis sight and will complete the construction of 250 additional beds in the fall of 1980. He also noted for the record a copy of a letter from Governor Quie supporting the project and a copy of a letter from Lloyd Zander, Commissioner of North Dakota, Department of Veterans Affairs supporting the project.

Jim Kinney ; Minnesota Coalition on Health Care Costs, speaking on behalf of Dr. Richard Fry. The primary thrust of Mr. Kinney's testimony are as follows: He felt that the concept of separation of review for Federal and private facilities was inappropriate and further that the decision of the planning agency with respect to the project should be the final one. In his testimony Mr. Kinney noted that the issue was not denial of benefits to veterans, but simply a question of the most effective way of delivering those health benefits to veterans.

John Tonneson; Disabled American Veteran , made the following points: He felt that each year the number of beds available at the V.A. becomes less and less. This does mean that the needs are less, just that the beds are reduced. Feels that the number 609 is too small. The early pitch to veterans was that there was not enough beds for hospitalization of veterans and therefore they were asked to contribute for the construction of the community hospitals. Now that the community hospitals are not filled, they want the Veterans Hospital closed so that they can get those patients. Feels that many veterans with service connected disabilities have to wait hours and hours for treatment. Feels that the Health Board is using its influence to reduce the regional hospital when only 50% of its patients come from the Metropolitan Area. What would patients from other states do? He feels that the volunteers working at the V.A. Hospital contribute quite a bit in keeping costs down, for example, buying T.V.'s for the patients and other items. He feels that this would not continue to happen if there were not a separate V.A. Hospital. Feels that the moral erosion is this country is evidenced by the decrease in the benefits to veterans.

Lynn Kiehne; Ms. Kiehne's testimony is included verbatum in the exhibits.

Robert Conner; Mr. Conner speaking as a private citizen and a disabled Vietnam Veteran.; Mr. Conner noted that many casualities of the Vietnam War are alive because of technology and feels that they will need more use of hospitalization because of the technological reasons that helped save their lives in Vietnam. He felt that if we disagree with the priority system of health care for the vets, we should simply say so. He felt that just because a veteran reached 65, that should not minimize the special needs of the veteran. He did not want to see the hospital facility size cut to a size that would be too small to keep its research and training programs. Noted further that none of the data took into consideration the possibility of another major war.

William Meyer; Dakota County Service Veteran Officer, his testimony is included verbatum. Mr. Meyer noted that today we all know that our military strength is decreasing and that one of the pitches from military recruiters is that the V.A. Hospital will be there for use by the veteran upon discharge. Mr. Meyer's other testimony is included verbatum in the exhibits.

O'Grady: Question: You say that as a recruiting tool recruiters are saying the V.A. Hospital will be of use. Are there no questions to that? Are there no qualifications to that?

Meyer: Response: If the veteran can pay the V.A will charge the patient and the V.A. would charge the private insurers if they were able to.

Foley: Comment ; A number of speakers today have pointed out the regional concept of the hospital. We understand that and we have understood that all along. I would appreciate it if all future speakers would omit reference to that fact.

Hazel HilTurk ; Mrs. Turk is a World War II Veteran. She was a flight nurse in the South Pacific and was disabled in and received service connected disabilities in that theater of operations. I feel that of all the things I have heard tonight the real question is money. If the shoe was on the other foot, what would you do? The V.A. provides good care and they should be allowed to continue to provide good care. I felt I just had to come tonight because we Veterans deserve the hospital. All the discussion on Medicare is not an excuse not to build the hospital. Think of all the co-payments and deductibles that are included in Medicare that veterans can not afford. Those co-payments and deductibles are going up all the time. Veterans that use private hospitals do so because they have jobs. What would happen if they lost their jobs and their health benefits? We are entitled to this care because we earned it. Also some veterans go to private hospitals because of the antiquated facility at the V.A. and that is the only reason. Previous questions have asked what is unique about the V.A. patient. Well there is the whole concept of commradeship. Also, if you lose faith with the older veterans, how are you going to get the young ones to go into the military?

Robert Callahan; Mr. Callahan noted as follows: The V.A. does not have the excess beds that the community does. He also noted that no one has asked the question as to what the responsibility of the taxpayer to the veteran is. He stated that the doctors are only interested in making more money.

Donald Kvidt; Mr. Kvidt was there speaking on behalf of the veterans who could not speak to the Board that night. He feels that the Minneapolis V.A. is one of the few centers that is doing adequate research in the whole issue of agent orange. He also felt that there would be many more psycological problems because of the delayed stress syndrome. These are the kinds of problems, and problem in other areas that only V.A. doctors see on a frequent basis, and therefore, are qualified to treat. Mr. Kvidt also noted that all the statistics for the bed need were predicated on the premise that there would not be another major war and he also felt that given the international attention and confict that we could go to war at any time.

Marlene Nelson; Speaking as a volunteer. As a volunteer she has heard many storys about veterans, and she feels the Board should know that they have little money or none at all. Sometimes this is because of nursing home costs, and the nursing homes have taken all the money from the people and there is no other place for them to go when they need hospital care. She thinks there is a special bond that exists between the patients at the V.A. Hospital and the V.A. Medical Team . It would be unfair to severe the veteran from his or her support system.

Lester Leider; Speaking as a private citizen and a tax paying citizen: He felt that as a foregone conclusion that the V.A. will be built, but that again, it was unfair that the private hospitals should be scrutinized under the Certificate of Need process and that Federal facilities are exempt from that process. He also noted that there was an acute shortage of nursing personnel and that construction of any facility at this point in time, should take into account that shortage of nursing personnel.

Wendel Peterson ;Speaking as a private citizen and a disabled American Veteran. Mr. Peterson noted that he had spent four years in Army and V.A. Hospital due to his wounds and felt that he was well qualified to speak from that perspective. He simply wanted to say this, that a number of years ago he was turned down because there was no hospital beds available, he felt that the hospital was needed, and that space problems are severe. He still has to go to outpatient clinics and can never find a place to sit down. The patients needs the beds. With respect to putting veterans in private community hospitals, it seemed to him that all the hospitals want is the money. The veterans should not have to do that. He felt that the veterans should get all the beds that they can get and ask the Board to reconsider their thoughts on the recommendation.

DISCUSSION

O'Grady: (To Mr. Cooney) With respect to the unique needs of the veterans, what do you think those unique needs are:

Cooney: (Response) ; First, obviously is the service connected disability. Second, reference has been made to problems with agent orange and delayed stress syndrome. This is not a service connected disability but is a unique health problem to veterans. Third is the unique service that we provide to patients in the areas of geriatric care and rehabilitation.

Foley: (Question) Who set the $221.4 Million Dollar Figure as an upper limit?

Conner: It is an estimated cost per conceptual plans from the firm of Ellerbe

Butler ; Does a veteran patient enter the system any differently than the private sector?

Conner: The majority are self referred.

Patel ; (Chief of Staff at V.A.) about 60% of our patients are self referral.

Butler (Question) Have you ever denied admittance of a veteran to the hospital, who needed hospitalization, because of lack of a bed.

Conner: A veteran who needs hospitalization has never been denied hospitalization, however elected surgery may, in certain instances, be postponed because of lack of beds.

Latner How many beds do you now have for chemical dependency?

Conner: We now have 41 and we are proposing 30, We are looking for greater emphasis on outpatient care. I am concerned about the bed reduction in the report because our hospital has constantly put beds out of operation as they were shown not to be needed. With respect to Findings of Fact No. 7B and 7C, I think where it breaks down, is what happens when a person reaches 65 years of age, they are no longer employed and therefore don't have that private health insurance and therefore there probably will be a change in the pattern of using doctors and hospitals. I also don't think that Finding of Fact No. 13 is valid. It only uses 20% of the veteran population and that is not accurate. You should use the total veteran population using hospitals at that time.

Caranicas: I would like to make a couple of points. The recommended size of 609 at the V.A. is based on V.A. data and other sources. The bed reduction is not recommended in order to fill empty beds in the community hospitals. Both the V.A. and ourselves feel that most of the data indicates that a bed reduction is inappropriate. At this point, Mrs. Caranicas read the conclusions of the Project Review Committee to the full board.

Stolitza: What is the V.A.'s response to the recommendations?

Conner: Without question, we could not continue to serve the veterans at that level of beds. The data is sought both at the V.A. level and at the Health Board level. I can tell you right now that we are treating up to 640 patients per day and that the population 65 and over is going to double by 1985. These are the facts that I know. The construction cost is not an area over which we have control. If we exceeded, we will have to go back to Congress and ask for more money. With respect to renal-transplantation and radiation therapy, those are under discussion. The other recommendations are reasonable. With respect to the nursing home, I think that there is a question in some peoples minds that the justification is adequate. I think that the nursing home bed size needs more looking at. I think that the GAO was instructed to look at the model. We are not planning to take 175 patients out of local community nursing homes.

The beds are absolutely not enough and will result in our having to reduce health care to eligible veterans.

Kumagai; If the veteran population over 65 is going to double in the next few years, the civilian population will double also, and that will be enough to fill up the civilian hospitals.

Hurley; Just one comment, at no time in this report, was the bed reduction recommended to fill up community hospital beds, either directly or indirectly.

Cooney: I would fortify what John has said, regarding excess hospital beds in the community. At no time in the review was this a consideration. This is a rationale objective attempt to look at the veterans needs.

Van Avery ; If the GAO said 725 and this board says 609, will,the GAO at any time change the figure?

Cooney: The model was provided by the GAO and the V.A. does the calculations. The model was complex because it analyses every patient record in a given year. I think it is perfectly reasonable to expect to see that that model and the calculations are reviewed, if this board wants to add language to that affect.

OGrady; Look at the recommendation. The recommendation is the important point, and it says that the number of beds should be supported by the data.

Kumagai; What do you think the penalty of 609 beds would be?

Cooney; I can neither accept or deny any of these recommendations, but it isn't fair for me to state my opinions, and I feel that 609 is too small a figure.

Houle; Just a few comments. I think that this was a good public hearing and I appreciate your patience in sitting here for this long. We have had the opportunity to look at the project from the viewpint of need. Need is not just that of the hospital, but also of the community. This is not a process to get someones money, because it is all of our money. What we are seeing is the future. We are seeing a struggle for a limited number of dollars for health care.

Jagolino Is this the right time to propose rewording of recommendation #1?

Houle: I think it would be more appropriate to move all the recommendations and the adoption of the report first.

Caranicas I move the adoption of the report and the Findings of Fact and Recommendations.

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Recommendations

1. The total hospital bed size (acute and non-acute) should not exceed that number of beds which supportable data suggests is needed. Analysis of the data provided in this report suggets that a maximum of 609 hospital inpatient beds (acute and non-acute) be constructed at the same site to replace the present Minneapolis VAMC inpatient hospital facility.

2. Construction costs (excluding movable equipment costs) of the VA hospital replacement project should not exceed $221,400,000.

3. The VA should plan to consolidate its programs in Radiation Therapy and Renal Transplantation at the University.

4. The VA should participate with its fellow hospitals in the Seven-County Metropolitan Area to achieve the goal of reducing the number of hospitals in the Seven-County Metropolitan Area operating open-heart surgery programs from 13 to 7 and reducing the number of cardiac catheterization laboratories from 13 to 9.

5. The VA should immediately integrate its plans for provision of nursing home beds and home care services with state and local providers and the HSAs in whose jurisdictions nursing home construction would take place.

6. It is appropriate for the Minneapolis VAMC to provide nursing home beds but until it works out an overall comprehensive plan with local providers the number of beds to be constructed should be limited to the 40 beds called for in the GAO model.

7. A common data base can be the most useful tool in analyzing and interpreting trends in data. The Veterans Administration should be required to participate in the nation-wide PSRO activity, thereby promoting uniformity and understanding between the private and federal sectors. At a minimum, the VA should be required to compare the results and methodology of its utilization review and quality assurance programs (SERP and SIR) to the PSRO program so that each can benefit from the strengths of the other's program. The results of such a comparison should then be made public. In addition, the VA should be required to incorporate the results of its Classification of Patients study as part of the documentation of need for any future hospital replacement projects to be submitted to the Congress.

Foley and Gunderson: Seconds

Jagolino: I now would like to move a friendly amendment to add a third sentence to recommendation 1.

"At a minimum, it is recommended that calculations based on the VA/GAO model should be updated using the Minneapolis VAMC's 1979 discharge data, 1977 PAS length of stay data; and that projected admissions for 1985, 1990, 1995 and 2000 reflect the different patterns of VA hospital preference between those now over 65 and those veterans who will reach 65 years of age in the decade of the 1980's.

Van Avery: Second.

O'Grady: I speak against it. We say that the size should not exceed what the data suggests it is. That should be good enough.

The vote on the amended motion failed 4-in favor 8-against 2 absentation

Stolitza: Does this mean that we are locked into 609?

Mhoon: No, look at the recommendation, it says that the size of the hospital should be supported by the data.

The final vote on the original motion was: 12-1 with 2 absentations

Metropolitan Health Board Report
on the
Minneapolis VAMC Replacement Project

April 30, 1980

Metropolitan Health Board
300 Metro Square Building
St. Paul, Minnesota 55101

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ABBREVIATIONS

OS	Average Length of Stay
CPHA	The Commission on Professional and Hospital Activities
M&S	Department of Medicine and Surgery (of the VA)
AO	General Accounting Office
SA	Health Systems Agency
HB	Metropolitan Health Board
AS	Professional Activity Stay (of the CPHA)
SA	Primary Service Area
FDIS	Space and Functional Deficiency Identificiation System (of the VACO)
ACO	Veterans Administration Central Office
AMC	Veterans Administration Medical Center

Section One

INTRODUCTION

A. National Health Care and Hospital Costs: A National Perspective

B. The Regional Perspective

C. Brief Overview of the VA Medical/Hospital System

D. Brief Overview of the Minneapolis VAMC

E. Scope of This A-95 Review

A. National Health Care and Hospital Costs

1. Overview

President Carter characterized hospital cost containment as "the most urgent anti-inflation measure proposed in the (original Fiscal Year 1981) budget." The pictogram on the following page illustrates the growth in health expenditures and the percent those expenditures represent of the gross national product. The Fiscal Year 1981 budget of the President estimates that health care expenditures will consume 10.5 percent of the gross national product by 1985 if "hospital cost containment legislation or other major changes in the health system" is unsuccessful.

As health expenditures have been consuming more of the gross national product, so too have hospital costs been consuming more of the health expenditure dollar. In 1970 hospital costs accounted for 37.2 percent of each health care dollar. In 1977 it rose to 40 percent. Projections by the Health Care Financing Administration indicate that hospital costs will consumer 41.7 percent of health care expenditures in 1985 and 44.1 in 1990. The balance between private and public expenditures for hospital costs has remained fairly stable in the last five years with the public sector paying 53-55 percent of all hospital costs.

Although the public portion of hospital costs has remained fairly stable the percentage of the public expenditures paid by Medicare has been increasing as shown in Table I below.

Table I
Percentage Distribution of Hospital Expenditures
by Selected Type of Public Expenditure[1]

Year	Total Hospital Costs ($)	All Public[2] Payments (%)	Federal Government (%)	Medicare (%)	VA (%)
1978[3]	$76,025,000,000	53.8%	39.9%	24.0%	5.5%
1977	$67,914,000,000	54.4	40.0	23.9	5.4
1976	$59,806,000,000	54.8	39.9	23.1	5.8
1975	$52,138,000,000	55.3	39.1	22.5	5.7

[1] Source: For years 1976-78: Health Care Financing Review, Summer 1979. For 1975: Social Security Bulletin, Volume 41, Number 7, July 1978.

[2] Includes both State and Federal Expenditures.

[3] Preliminary estimates.

Table II illustrates the percentage of all Federal payments by the Medicare and Veterans Administration Programs for hospital care.

FIGURE 1: NATIONAL HEALTH CARE EXPENDITURES

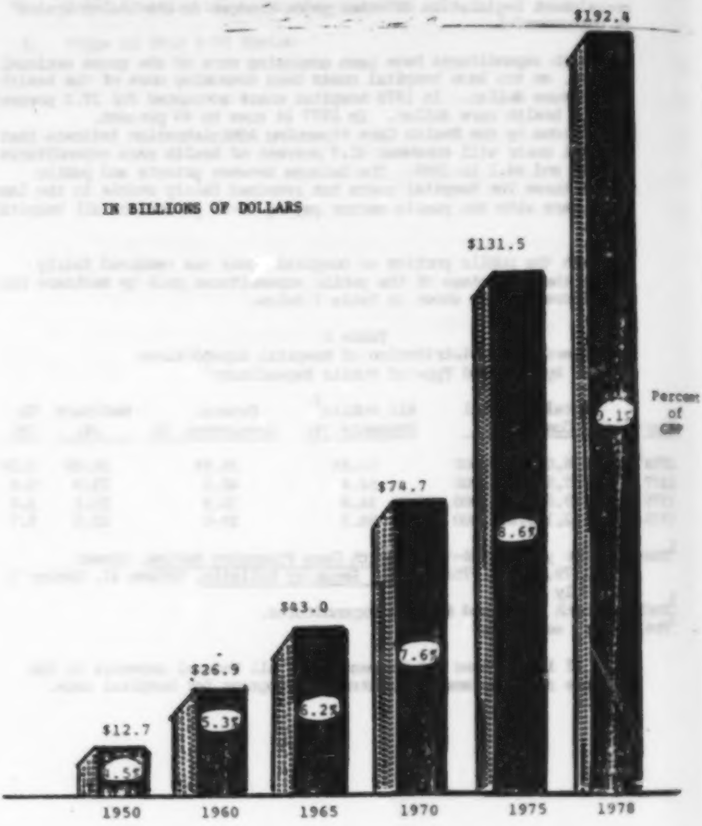


Table II

Percentage Distribution of Medicare and VA Hospital Expenditures to All Federal Expenditures for Hospital Care[1]

Year	Total Federal Payments ($)	Medicare (%)	VA (%)
1978[2]	$30,344,000,000	60.23%	13.65%
1977	$27,141,000,000	59.74	13.45
1976	$23,880,000,000	57.75	14.44

[1] Source: For years 1976-78: Health Care Financing Review, Summer 1979. For 1975: Social Security Bulletin, Volume 41, Number 7, July 1978.

[2] Preliminary estimate.

The increasing share of Medicare payments of public expenditures for hospital costs, while all public expenditures have remained fairly stable, results from decreasing payments for hospital costs by states and local units of government.

2. Effect of Hospital Costs on the Individual

The source of Medicare hospital payments rests with the average wage earner. Such Medicare funds are obtained from the social security tax. Table III below illustrates the social security tax rate for 1979-1985 and the wage base which is to be taxed.

Table III

Social Security and Hospital Insurance (Medicare) Tax Rates for Selected Years between 1979 and 1985

	1979	1980	1981	1982	1985
Tax Rate as Percent of Income (employer and employee)	12.26	12.26	13.30	13.40	14.10
Medicare Portion of Tax Rate	2.10	2.10	2.60	2.60	2.70
Medicare Percent of Tax Rate	17.13	17.13	19.55	19.40	19.15
Earnings Taxed ($)[1]	22,900	25,900	29,700	32,400	42,900
Annual Medicare Payment Per Capita ($)	481	544	772	842	1,158

[1] Earnings taxable for 1982 and 1985 are estimates based on automatic adjustment clauses in current legislation.

The per capita figures represent the combined Hospital Insurance (Medicare) tax each person and his/her employer pay on an annual basis. The employer and employee each contribute an equal share. The increase from $481 in 1979 to $1,158 in 1985 illustrates, perhaps, the need for cost containment in the hospital sector.

Another reason for increased social security taxes (as well as the Medicare component of that tax) is that the ratio of beneficiaries to wage earners is increasing. In 1950, the ratio of those over 65 to those 21 to 64 was 14.4 percent or one beneficiary to every seven employed people. In 1970 it was 19.3 percent or one beneficiary to every five employed people. By the year 2025 it is projected to be 31.2 percent or one beneficiary to every three employed people. These figures simply mean that less people will be funding the Social Security/Medicare programs for more beneficiaries.

The need to increase the fiscal efficiency of hospital programs to cut costs has been recognized by the VA, not only in the bed reduction of its system, but also in repeated, although unsuccessful, legislation which would allow the VA system to seek reimbursement from health insurers for the treatment of insured veterans with non-service connected disabilities.

Veterans with non-service connected disabilities represent 70 percent of all patients treated at the Minneapolis VAMC and 75 percent of VAMCs in the U.S. It is unclear what portion of all veterans are currently insured for hospital and medical benefits.

However, a VA study of admissions to VA hospitals during a one-week period in March of 1975 indicated that:

- 65.7 percent of VA patients had no health insurance coverage,
- 17 percent were covered by Medicare (a one-day census of patients in VA hospitals on October 1, 1975 indicated 24.5 percent of the patients on that day were over 65),
- 2 percent were covered by Medicaid, and
- 18 percent were covered by private health insurance.

What is clear, however, is that the veteran population as a whole is aging; and that just as a veteran is eligible for VA hospital/medical benefits when he/she reaches 65, the veteran will also be eligible for Medicare coverge upon reaching 65. This has the effect of creating a duplicated public health care coverage system for the veteran population over 65.

Today 2.7 million veterans are over 65. By 1995 that number will almost triple and reach 8 million. By 1990, 50 percent of all U.S. males over 65 will be veterans and by 1995 over 60 percent of all U.S. males over 65 will be veterans. Failure to integrate planning for hospital resources for veterans with the non-veteran could result in duplicative hospital resources being planned for almost one-fourth of the population over 65.

Use of Medicare resources for the veteran over 65 would create economic problems for the veteran in the form of Medicare co-payments and deductibles. This could be redressed through legislation.

It appears that most veterans would qualify for Medicare. In his 1978 report to the Congress, Max Cleland, Administrator of Veterans Affairs, reported that wartime veterans had a median personal income of $13,540 in calendar year 1977 compared to $9,050 for non-veterans. In fact, for every age group veterans had higher median incomes than the non-veteran counterpart.

B. The Regional Perspective

1. Trends in Hospital Utilization

The Metropolitan Health Board has consistently pursued a Metropolitan or Regional perspective when analyzing the need for significant capital expenditures within the Area. This is particularly true for hospitals and nursing homes, where costs have been consuming an increasingly greater portion of the health care dollar. Table IV displays the percentage change in national health expenditures by category since 1960.

Table IV
Selected Percentage Changes in National Health Expenditures
By Category

	1960	1970	1977
Hospitals	33.8%	37.2%	40.0%
Nursing Homes	2.0	6.3	7.9
Construction	3.9	4.6	3.0
Total Expenditures in Billions	26.90	74.7	170.0
Percent of GNP	5.3%	7.6%	8.8%
Per Capita	$146	$359	$769

Basing the need for significant capital expenditures on the total needs in the Metropolitan Area is reflected in the policies, goals and guidelines of the Acute Inpatient component of the Health Systems Plan. At the same time, the Board also recognizes that the need for certain facilities such as the University of Minnesota Hospitals, Abbott-Northwestern Hospital and other facilities which serve as major tertiary referral centers must also be evaluated on this pattern of immigration. The Minneapolis VAMC is recognized as such a facility. According to patient origin information submitted by the VAMC, 52.6 percent of all discharges orginated from within the Seven-County Metropolitan Area in 1979. The guidelines in the Acute

Inpatient Care component regarding the need in a defined service area reflect how the Health Board examines the need for hospital services within the context of Metropolitan need when significant numbers of patients and patient days come from outside the Metropolitan Area.

The necessity to base decisions on Metropolitan need can be visualized from Table V which provides the use rate for acute hospital services in the Metropolitan Area for the last nine years. It should be noted that data on patient days used by residents of the Metropolitan Area at the Minneapolis VAMC are included in the use rate calculations. As can be seen in Table V, the use rate of hospital services (patient days per 1,000 population) has shown a continued decline since 1970. Two major factors which affect the volume of hospital patient days are use rate and population. Although the Metropolitan Area population has been increasing since 1970, the use rate has been decreasing. Consequently, the number of acute patient days has held relatively constant even with immigration of patients from outside the Metropolitan Area. Taking a closer look at the reasons behind the decline in use rate, it is clear that the primary factor has been the overall decline in average length of stay (ALS) within the hospitals in this area. Since 1970 the ALS for med/surg patients hospitalized in the Metropolitan Area has declined from 9.0 to 7.1 in 1978. Several reasons have been advanced for this change. However, it is recognized that several factors have all contributed to this change, particularly the growth of HMOs in this area, the effectiveness of the PSRO, the impact of Rate Review and the impact of the planning process itself.

While the overall number of hospital patient days is relatively stable it is noteworthy that the absolute number of patient days generated in Metropolitan hospitals in 1978 was less than what was generated in 1970. This is shown in Table VI on the next page.

Table V
Use Rate in the Metropolitan Area
1970-1978

Year	Med+P[1]	All Acute Services[2]
1970	1,000	1,190
1971	984	1,150
1972	958	1,129
1973	944	1,116
1974	940	1,129
1975	907	1,137
1976	919	1,152
1977	873	1,120
1978	837	1,091

[1] Medical, Surgical and Pediatrics
[2] Includes Med+P and OB, Psych and C.D.

Table VI
Use Rate, Population and Patient Days
In the Metropolitan Area, 1970-1978

Year	HSP Use Rate	Population	Patient Days (000) Med/Surg	Patient Days (000) Acute
1970	1,000	1,874,612	2,013	2,664
1971	984		2,012	2,622
1972	958	1,918,315	1,986	2,575
1973	944		1,986	2,559
1974	960	1,948,795	2,045	2,624
1975	987		1,954	2,654
1976	919	1,965,435	1,990	2,702
1977	873	1,976,460	1,980	2,641
1978	836	1,990,760	1,827	2,586

Figure 2 on the following page illustrates the medical/surgical/pediatric use rate decline between 1970 and 1977.

This declining use rate along with a slow but steady population growth leads to a conclusion that the Average Daily Census in hospitals in the Metropolitan Area will continue to decrease until the mid-1990s as shown in Table VII.

Table VII
Projected Utilization Trends
For the Metropolitan Area[1]

Year	Use Rate	Population	Average Daily Census
1980	1,050	2,027,700	7,000
1985	925	2,125,500	6,451
1990	800	2,222,500	5,845
1995	800	2,300,500	6,050

[1] From 1979-80 HSP. ADC includes immigration.

This declining use rate means a declining use of hospital resources until utilization stabilizes. Estimates of the point of equilibrium differ but 600 to 800 acute patient days per 1,000 population is one parameter that is used quite often.

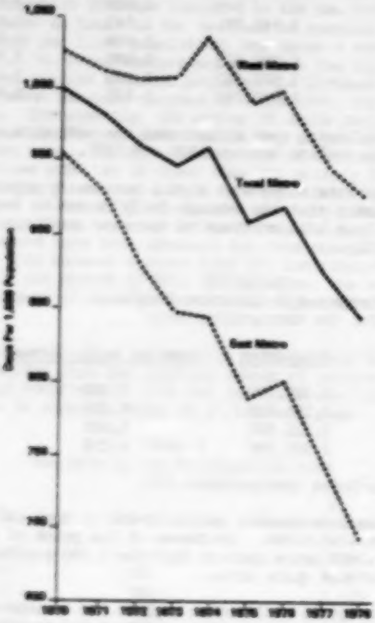
These trends in hospital utilization support the concept of a Metropolitan or Regional perspective, and have led the Health Board, in concert with the provider community, to adopt goals to reduce approximately 2,000 excess acute hospital beds and to consolidate, merge or phase out specialty services which do not meet adopted guidelines.

2. Hospital Long-Range Planning and Bed Reduction Effort

Hospitals in the Metropolitan Area and the Health Board have been engaged in a mutual long-range planning effort over the past several years. During 1976 in response to the growing excess in hospital capacity, the Health Board began attaching conditions to Certificate

FIGURE 2:

HOSPITAL USE RATES FOR
MEDICAL-SURGICAL AND PEDIATRICS SERVICES
1970-1977



Source: Metropolitan Health Board

of Need approvals that required hospitals to submit long-range plans. The Health Board recognized, however, that this did not constitute an integrated, systemwide approach. Consequently, a Long-Range Hospital Planning Task Force comprised of consumers, hospital administrators and medical personnel was formed. This Task Force met for several months and eventually prepared a process and schedule for long-range hospital planning in the Metropolitan Area.

The process called for each hospital to submit a long-range plan to the Metropolitan Health Board. An initial draft was to be submitted in January 1978. After review and consultation with Health Board staff and Board members, a final Phase I long-range plan was to be submitted in October 1978. By early 1979, all general, non-Federal acute hospitals in the Metropolitan Area submitted their final Phase I long-range plan to the Health Board. The only exception was the Minneapolis VAMC, which indicated that they could not submit such a draft plan to the Metropolitan Health Board since the planning was done in Washington and no plans were available. Metropolitan Health Board staff and the Health Board chairperson visited with the administrator of the Minneapolis VAMC and toured the facilities in the spring of 1979.

As a result of hundreds of meetings, involving thousands of hours of volunteer time, the Health Board adopted a phased methodology with criteria and procedures for reducing the excess hospital capacity within the Metropolitan Urban Service Area. Based on the many commitments made during the development process, the Health Board anticipates that the hospital system and the community will realize the closure of approximately 2,000 non-federal licensed acute hospital beds and the reduction of unnecessary services by the end of 1983. This phased process and criteria have been published in the report entitled Long-Range Hospital Plan for the Twin Cities Metropolitan Area. Currently, the Plan is in its third phase.

The second phase was intended to document the individual hospital's commitment to the phased reduction process and calls for the reduction of two-thirds of the bed reduction at each institution, within the MUSA, necessary to achieve an institutional occupancy rate of 80 percent (70 percent for children's hospitals). Table VIII illustrates the beds which were to be reduced by December 31, 1979 at each institution as a percentage of each hospital's licensed beds. It also shows in parentheses the actual number of beds to be reduced to meet the Phase II guidelines. Since the VA hospital had indicated that it could not participate in the long-range planning process, this table does not indicate the impact the Phase II request would have had on the VAMC. If the VAMC were included in the table, the number of beds it would have reduced would have been 60.

Table VIII
Acute Hospital Beds to be Reduced in Phase II
By December 31, 1979
As a Percentage of Licensed Acute Beds

FCH System 10.4%			St. Paul-Ramsey	15.6%	(81)
Lutheran Deaconess	10.8%	(47)	Bethesda	11.4%	(34)
Fairview	11.5%	(45)	Midway	10.1%	(34)
Fairview-Southdale	4.0%	(16)	Mounds Park	10.9%	(24)
Health Central, Inc. 9.4%			Samaritan	40.7%	(61)
Golden Valley	15.7%	(59)	Riverview	28.0%	(21)
Mercy	3.8%	(11)	St. John's	7.3%	(26)
Unity	6.6%	(18)	St. Joseph's	19.8%	(106)
Abbott-Northwestern	9.1%	(79)	United	20.3%	(141)
Eitel	19.4%	(28)	Children, St. Paul	6.5%	(7)
Methodist	8.1%	(36)	Divine Redeemer	16.2%	(21)
HCMC	11.3%	(55)			
Mt. Sinai	6.2%	(17)			
North Memorial	10.1%	(55)			
St. Mary's	3.0%	(18)			
Metropolitan Medical Center	15.2%	(111)			
University of Minnesota	15.3%	(126)			
Mpls. Children's	14.8%	(20)			

To provide an additional perspective on the potential implications for each institution if all of the licensed acute care beds were reduced to achieve an overall occupancy rate of 80 percent, Table IX is presented below:

Table IX
Acute Hospital Bbeds to be Reduced
To Achieve an Overall Occupancy Rate of 80 Percent
As a Percentage of Licensed Acute Beds[1]

Health Central Inc.	14.2%	123	St. Paul-Ramsey	23.9%	123
Abbott-Northwestern	13.8%	120	Bethesda	17.1%	51
Eitel	29.9%	43	Midway	15.4%	52
Methodist	12.4%	55	Mounds Park	16.4%	36
HCMC	17.3%	84	Samaritan	62.0%	93
Mt. Sinai	9.5%	26	Riverview	42.7%	32
North Memorial	15.2%	83	St. John's	11.2%	39
St. Mary's	4.5%	27	St. Joseph's	30.0%	161
MMC	23.1%	168	United	30.8%	214
University	23.2%	191	St. Paul Children's	10.3%	11
Mpls. Children's	22.9%	31	Divine Redeemer	24.6%	32
FCH System	15.6%	163			
Fairview				17.4%	68
Lutheran Deaconess				28.4%	71
Fairview-Southdale				6.0%	24

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[1] Actual number of beds follows percentage figure.

Since the release of the Phase II request to reduce excess beds in local hospitals, all hospitals have stated their commitment in writing to cease to operate the requested number of beds as indicated above. In total, approximately _____ beds have been removed from service according to the Phase II guidelines.

It should be recognized that the purpose of this entire planning process is not just to reduce beds, but to reduce excess operating service capacity and the resultant excess in operating expenses. Beds are a proxy indicator. The real containment of the rise in costs will take place only when those units that are needed provide cost effective services in appropriate geographic areas throughout the Metropolitan Area. This is particularly true of the specialized services which have been identified in the HSP as being in substantial excess capacity within the Area. Therefore, the overall objective is to both reduce excess licensed bed capacity by approximately 2,000 non-federal beds and to consolidate specialized services. The extent to which reducing licensed acute beds and consolidating specialized services results in containing the rise in hospital costs depends on the method of bed reduction. Ranked in order of most cost effective to least cost effective for the system are the following methods:

- closing entire inpatient acute hospital facilities combined with closing entire specialized service departments;
- closing entire inpatient acute hospital facilities without closing entire specialized service departments;
- closing entire specialized service departments;
- closing entire nursing stations without closing the entire service department;
- closing individual beds that are staffed and operated; and
- closing individual beds that are not staffed and operated.

In all cases, the extent to which new construction and remodeling occur in the system will vary the relative cost effectiveness of closing services and facilities.

Phase III of the Long-Range Hospital Plan involves the merger, consolidation or phase-out of specialized services which do not meet the Health Board's guidelines. This Phase is scheduled to be completed by December 31, 1980. The Long-Range Hospital Plan details the special criteria to be used by the Health Board to identify which hospitals and specialized services should be consolidated, merged or phased out.

Phase IV involves the phasing out of the additional beds necessary to reduce the entire system by 2,000 non-federal licensed acute beds (based on 1976 licensed beds) by December 1983, including the designation of whole hospitals to be closed. Any beds closed after 1976 are considered part of the 2,000 licensed bed reduction.

The Health Systems Plan incorporates, within the guidelines to be used when receiving Certificate of Need applications, many of the criteria contained in the Long-Range Hospital Plan. Certificate of Need reviews will take into account in the review process the extent to which the hospital undergoing review has participated in the four-phase process.

In addition, as the process moves forward, the extent to which all hospitals have participated toward meeting the reduction goals will be a continuing consideration in performing Certificate of Need reviews, including requests for replacement of existing service capacity.

3. Economic Impact Analysis

The total estimated non-federal hospital expenditures for inpatient care in the Seven-County Metropolitan Area for the last three years are:

1977	$613,900,000
1978	670,830,000
1979	736,870,000

The increase between 1977-1978 is $56,930,000 and the increase between 1978-1979 is $66,040,000. This $66,040,000 increase exceeds the 1979 budgets of all of the general, non-Federal acute hospitals in the Metropolitan Area except for the University and Hennepin County Medical Center.

Since up to 90 percent of hospital reimbursement is covered by third party reimbursement, these increases in hospital costs are not directly felt by individuals. However, one method to assess the effect on the individual is to examine the portion of an individual's FICA (Social Secutiry) Tax that is sent to the Hospital Insurance Trust Fund which is the source of Medicare payments to hospitals.

Set forth below is the amount each individual pays on an annual basis or will pay according to scheduled increases.

Table X
Hospital Insurance Trust Fund Component
of FICA Tax

Year	FICA Tax[1]	HI[1]	Salary Limit	Annual HI Tax
1977	5.85%	0.9%	$16,500	$148.50
1978	6.05%	1.0%	17,700	177.00
1979	6.13%	1.05%	22,900	240.45
1980	6.13%	1.05%	25,900	271.95
1981	6.65%	1.3%	29,700	386.10

[1] The FICA Tax is comprised of two parts: Social Security Tax and tax for the Hospital Insurance Trust Fund (HI). In 1979 the FICA Tax was 6.13 percent with Social Security being 5.08 percent and HI 1.05 percent.

The salaried individual who made $16,500 or more in 1977 would have contributed $148.50 to the Hospital Insurance Trust Fund for Medicare payments. In 1979 the amount rose to $240.45 which is a 62 percent increase. In 1981, the amount will be $386.10 on a salary of $29,700 or more and this will be a 61 percent increase over 1979. The employer of the salaried individual pays an amount equal to that of the individual.

Even with this payroll tax, the HI Trust Fund had insufficient funds to meet its Medicare obligations to hospitals in 1977 and had to obtain almost $1 billion from the General Treasury for Medicare payments to hospitals.

Thus, even though third party reimbursement removes the direct impact of hospital costs from individuals, the individual does pay for these costs. Since hospital occupancy is lower than desirable there are obvious reasons to ensure that the availability of hospital services at a local level is analysed within the framework of a broader regional need.

The extent to which consolidation and phase-out of excess hospital capacity in the Metropolitan Area can assist to contain the rise in hospital costs was studied by Price Waterhouse and Company under a study commissioned by the Health Board in 1978. The study examined the potential cost savings and net economic impact of closing 2,000 non-federal licensed acute hospital beds in the Metropolitan Area by 1983, and whether closing whole hospitals was the most cost effective method of reduction. The study explored three scenarios.

The first scenario involved the closure of six "average" hospitals which would total 2,000 beds. The second scenario involved closure of six whole hospitals, specific services in five other hospitals and beds in six other hospitals. The third scenario involved closing six whole hospitals, specific services in two other hospitals, beds from eleven other hospitals and construction of a new 150-bed hospital.

Costs and savings, as determined by the study, are summarized below:

Table XI
Net Economic Impact
of Hospital Bed Reduction
Based on 1976 Data

	First Year Savings		First Year Costs*		Annual Savings After First Year
	Maximum	Minimum	Maximum	Minimum	
Scenario 1	$60,296,000	$24,825,000	$17,028,000	$(18,443,000)	$41,853,000
Scenario 2	28,464,000	12,546,000	2,239,000	(12,678,000)	14,785,000
Scenario 3	27,602,000	11,174,000	(3,053,000)	(19,481,000)	8,121,000

*Parentheses indicate a net benefit in closure costs, due to the sale of land and buildings and the liquidation of current assets.

Source: Price Waterhouse and Company 1978 study.

Several key assumptions were made in the study which ought to be mentioned. First, the methodology assumes that hospital staffing in the daily hospital service and ancillary departments is directly related to occupancy. Therefore, a reduction of licensed, but unoccupied beds, will not precipitate any change in hospital operating costs.

Secondly, first year savings are determined by subtracting maximum first year costs of closure from annual savings. Closure costs include retirement of long-term debt, liquidation of current assets, unemployment compensation and employee retraining.

Third, the primary care physician is the chief determinant of how patient days would be redistributed between closed and open facilities; patient days would remain constant.

Fourth, the analysis of how costs change in particular hospitals with changes in patient days must be accomplished by analyzing the different types of costs.

- Salaries will vary directly with full-time equivalents (FTEs). FTEs will change either in proportion to changes in patient days or not at all, depending upon the department within the hospital in which the employees work.
- Fringe benefits vary directly with salaries.
- Variable natural expenses, while changing for a particular hospital as patient days change, do not change for the system as a whole.
- Fixed natural expenditures will change only if an entire hospital is closed.
- Certain costs, such as education and direct outpatient related costs, will not change for the system as a whole even if particular hospitals are closed.

The study provided the community with two key elements in the planning process.

(1) It supported the Health Board's assumption that closure of whole hospitals will produce cost savings to the health care system even after subtracting the costs of closing hospitals.

(2) It provided a methodology to analyze the impact of bed reductions, service consolidations and hospital closures.

4. Calculation of Projected Bed Demand

The calculation of a quantity representing future inpatient hospital bed demand is essential to any planning effort attempting to ensure the availability of hospital services sufficient to meet future needs or demands. In hospital planning, the Metropolitan Health Board, by policy decisions, considers inpatient hospital services as services to be planned on a Metropolitan or Regional basis. At the same time, the Health Board recognizes that hospitals within the Metropolitan Area serve as major referral centers for persons from outside the area, including outstate Minnesota, and the Upper Midwest. Based on data obtained in the 1978 hospital patient origin study, approximately 17 percent of all patient days were used by persons outside the Metropolitan Area. Specific hospitals have greater inmigration than others and this is recognized as legitimate demand for service. This overall approach has been used in this Metropolitan Area since the formation of the two voluntary hospital planning councils in the early 1960s and is presently documented in the Health Systems Plan. It has been used in all hospital Certificate of Need applications for new or expanded inpatient hospital services since then.

The Health Board has conducted a biennial hospital patient origin study since its formation in 1970. Prior to 1970 the voluntary hospital planning councils used hospital patient origin data provided by statewide patient origin surveys using essentially the same methodology as used today. These studies have been conducted since 1963-64. Data generated by the Health Board's patient origin studies is felt to be very complete and the most accurate information available for making system-wide assumptions regarding hospital service areas and use. All of the studies include all discharges during a one-month period from all general acute short-stay hospitals except the Veterans Administration Hospital. The patient days recorded in this total one-month sample are then compared to the monthly Midnight Census Report, a monthly summary of all patient days by service by hospital for all patients using Metropolitan Area hospitals. Over the years this comparison has indicated that the information is very accurate and consistent, even though different months have been used from time to time as the month for data collection. For example, the variance in patient days between the 1978 patient origin study and the 1978 Midnight Census Report is 0.5 percent.

Before actual bed demand calculations are discussed, one further point must be made. The presently adopted approach used by the Health Board uses bed demand calculations which are based on the actual use of inpatient hospital services by the population. As such, it is assumed that the most recent use rates (patient days/1,000 population) are appropriate. This use rate is then assumed to be constant and applied to projected population estimates. Based on the information contained in part 1 of this section, which relates to projected declining use rates until the mid-1990s, bed demand projections using this methodology will probably overstate the demand for inpatient beds. Therefore, the approach used calculated demand but does not necessarily calculate bed need, or the capacity projected to be needed by the population if the use rate continues to fall or should actually be less than the last rate calculated.

The following table indicates the bed demand for the entire Metropolitan Area for total acute inpatient care using the 1978 utilization data to calculate bed demand.

Table XII
Total Acute Hospital Care Bed Demand Projections for the Metropolitan Area[1]

	1980	1985	1990
Licensed acute care beds as of December 31,1976[2]	11,104	11,104	11,104
Acute care bed demand at 80 percent occupancy based on 1978 use rate	9,082	9,521	9,955
Excess beds	2,022	1,583	1,149

[1] Includes Med/Surg/Peds plus CD and Psych.

[2] 1976 is used because the Long-Range Hospital Plan sets that date for calculating needed bed reduction in the system.

Another way to look at the demand for inpatient care is to look at the need for medical/surgical and pediatric services, which represent about 82 percent of total acute beds. Using only these services, the following table indicates the projected bed demand for the entire Metropolitan Area for medical/surgical and pediatric inpatient care using the 1978 utilization data to calaculate bed demand.

Table XIII
Medical/Surgical/Pediatric Bed Demand Projections for the Metropolitan Area

	1980	1985	1990
Licensed M/S/P beds as of December 31, 1976	9,086	9,086	9,086
M/S/P bed demand at 80 percent occupancy based on 1978 use rate	6,966	7,302	7,636
Excess beds	2,120	1,784	1,450

C. Brief Overview of the VA Medical/Hospital System

The Department of Medicine and Surgery (DM&S) of the VA is charged by law with the responsibility of providing complete medical and hospital care to eligible veterans. The DM&S is one of three main departments of the Veterans Administration. The other two are the Department of Veterans Benefits and the Department of Memorial Affairs.

The DM&S was established in January of 1946 pursuant to legislation passed by the 79th Congress in December of 1945 (P.L. 79-293). This law called for the upgrading of existing VA hospitals to provide for the medical needs of returning World War II veterans. One of the reasons for the establishment of the DM&S was the lack of physicians and nurses then serving in the VA. In 1945, the VA operated 97 hospitals. When World War II was over, surplus Army and Navy hospitals were transferred to the VA and by 1948 the VA was operating 125 hospitals. In addition, a hospital construction program was begun and by 1955, the VA was operating 173 hospitals.

General Omar Bradley was appointed the Administrator of the VA in August of 1945. One of his first actions was to call for the development of working agreements between VA hospitals and the nation's medical schools. The Minneapolis VAMC was the first VAMC to become affiliated.[1] Today there are some 2,000 affiliations or cooperative training arrangements between VA facilities and schools of medicine, dentistry, nursing and other allied health professions.[2] During 1978, 136 VA hospitals were affiliated with 104 medical schools and 85 VA hospitals had affiliations with 58 dental schools.

In FY 1978, the VA operated 172 hospitals and 91 nursing homes treating a total of 1,342,164 patients. Outpatient visits totaled 17,416,274. Its operating budget (including research activities) was $5,058,500,000. In addition to short term medical, surgical and psychiatric services, it also provides specialized medical services in such areas as blind rehabilitation centers, epilepsy centers, prosthetic treatment and spinal cord injuries.

The provision of quality health care to veterans is the mission and role of the VA (DM&S) system. Concurrent with its mission of providing high quality care are its functions in research and health manpower training. To aid the implementation of this mission, the VA has organized a regionalized approach for delivery of health services by dividing the nation into 28 medical districts. The objectives of the regionalization are:[3]

- improve patient care through the most effective and efficient use of available resources.
- improve utilization of available VA and community health resources and facilities.

D. Brief Overview of the Minneapolis VAMC

The Minneapolis VAMC is located on 111 acres in south Minneapolis. It consists of a complex of buildings, some of which were constructed as early as 1927. The main hospital building was constructed in 1953 and is an eight-story, 464-bed facility. The center currently is operating 738 hospital beds throughout the complex. Exhibit 1 at the end of this report is an illustration of the VA campus.

As noted earlier, the Minneapolis VAMC was the first VAMC to become affiliated with a medical school. Today about one-half of all residents and one-third of all medical students at the University of Minnesota's Medical School receive some of their clinical training at the VAMC. In fact, the local VA has one of the largest educational training programs in the VA, ranking in the top one percent of all VA medical facilities. This educational affiliation has served not only the VA, but also the civilian population of Minnesota and the Upper Midwest who have been the recipients of the experience gained by the health care professionals who have used the VAMC during their clinical training.

The local VAMC also has one of the largest research budgets ($4,075,990 in FY 1980) in the VA system and operates a number of specialized medical services such as cardiac catheterization, electron microscopy, prosthetic research and treatment, renal transplantation, stereotactic brain surgery and radiation therapy treatment. As such, the Minneapolis VAMC should be considered one of the premier VA hospitals in the nation.

The primary service area of the Minneapolis VAMC is determined by the VACO. The Minneapolis VAMC's primary service area (PSA) includes 54 counties in Minnesota, 16 counties in Wisconsin and 2 counties in Iowa. Figure 3 on the following page illustrates the PSA and those of the VA hospitals in Fargo and Sioux Falls. These three hospitals provide the medical, surgical and short-term psychiatry services to veterans in Medical District 18.

In FY 1979, 87.6 percent of all discharges (excluding dialysis) at the Minneapolis VAMC came from its PSA. At the same time, 52.6 percent of all discharges came from the Seven-County Metropolitan Area. This constitutes a relatively stable pattern because FY 1978 data shows that 51 percent of all patients were from the Seven-County Metropolitan Area and 1976 data indicates that 51.6 percent of all patients were from the Metropolitan Area. Figure 4 on a following page illustrates the above statistics.

E. Scope of This A-95 Review

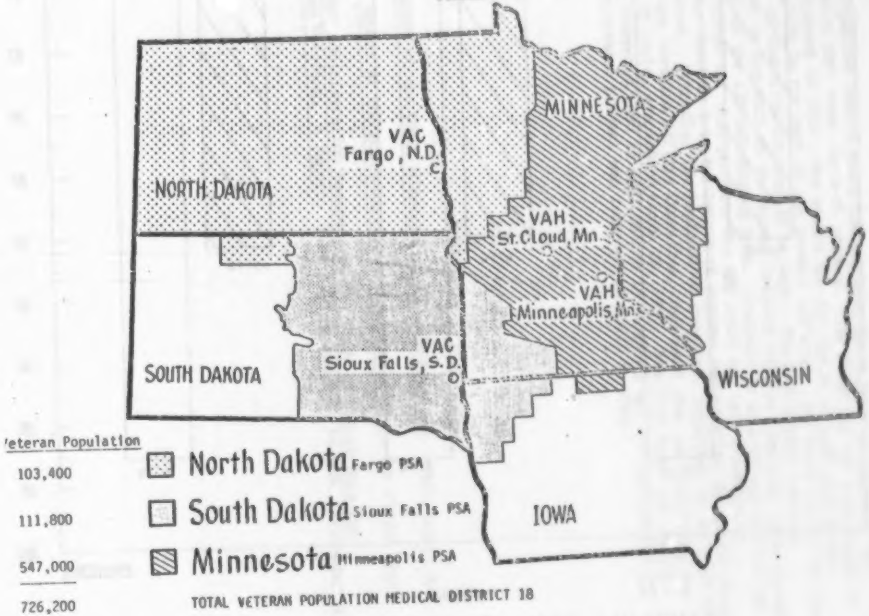
The review of the proposed VAMC replacement project is a common function of a regional planning and coordinating body such as the Metropolitan Council. The fact that the VAMC serves a wider area than the Seven-County Metropolitan Area does not mean it is unusual for such reviews to take place. In fact, the University of Minnesota Hospitals, which must receive a Certificate of Need for all new programs or expenditures exceeding $150,000, reports that fewer of its patient days (percentage-wise) come from the Metropolitan Area than do the patient days at the VA. In 1976 and 1977 about 40 percent of the patient days at the University came from the Metropolitan Area while the VA found that 50 percent of patient days in 1978 came from the Metropolitan Area.

The Metropolitan Health Board of the Metropolitan Council is reviewing this project pursuant to what is known as an A-95 Review. These reviews come as a result of Title IV of the Intergovernmental Cooperation Act of 1968 which authorized the Office of the President to establish a method for the evaluation and review of Federal projects that had a significant impact on area or community development. The purpose of the legislation was to ensure (to the extent possible) that Federal expenditures, consistent with national objectives, were consistent with state, regional and local objectives and planning efforts.

Subsequent regulations published by the Office of Management and Budget had a specific provision for Health Systems Agencies to review Federal projects involving capital expenditures exceeding $200,000 (with certain maintenance projects excluded) which would be spent for the modernization of Federal inpatient facilities. The OMB regulations say that HSAs are "expected to evaluate proposed Federal projects for consistency with areawide and local health delivery plans and health supply-demand situations."[3]

MEDICAL DISTRICT # 18
PRIMARY SERVICE AREA

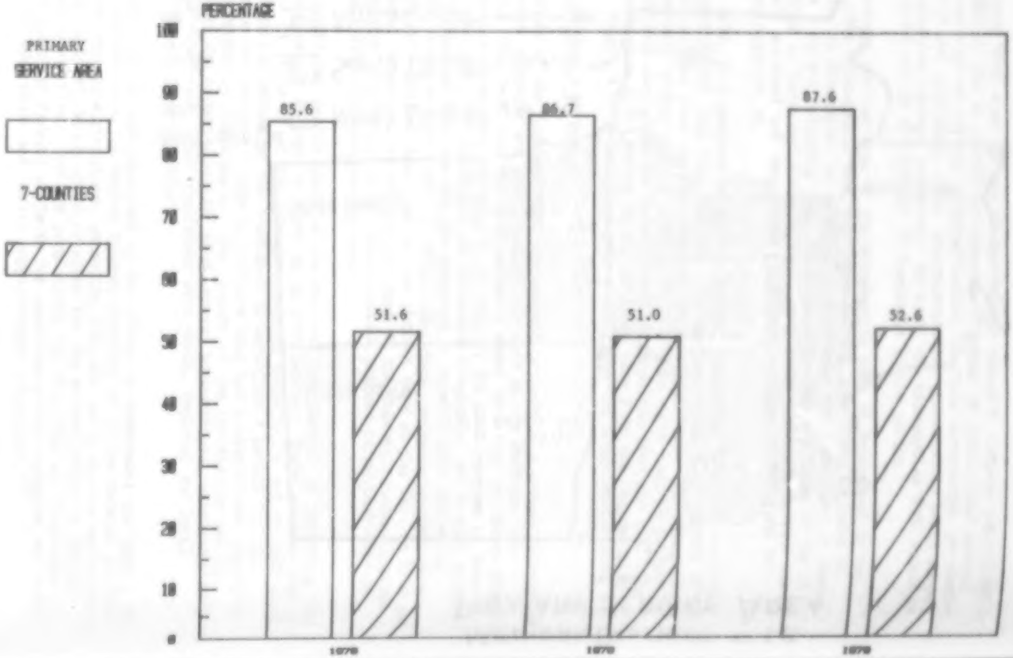
FIGURE 3


NORTH DAKOTA
VAC
Fargo, N.D.
SOUTH DAKOTA
VAC
Sioux Falls, S.D.
MINNESOTA
VAH
St.Cloud, Mn.
VAH
Minneapolis, Mn.
WISCONSIN
IOWA

Veteran Population	
103,400	▩ North Dakota Fargo PSA
111,800	▧ South Dakota Sioux Falls PSA
547,000	▨ Minnesota Minneapolis PSA
726,200	TOTAL VETERAN POPULATION MEDICAL DISTRICT 18

GEOGRAPHIC ORIGIN OF VAMC PATIENTS

FIGURE 4



The Metropolitan Health Board has reviewed two earlier projects of the Minneapolis VAMC under the A-95 process. The first was the acquisition of a C.T. scanner in 1976. The second was for the $4,000,000 plus Boiler Plant (which is now part of the present project). Two minor points for the purpose of clarification need to be made. The Replacement Overview submitted by the VACO to the Senate Veterans Affairs Committee inferred MHB approval of the 120-bed nursing home. Inasmuch as an A-95 application was not submitted for that project, the MHB could not have recommended approval. Exhibit 2 is the letter of comment recommending the Boiler Plant replacement. Secondly, the Replacement Overview, submitted by the VACO to the Senate Veterans Affairs Committee, indicated that the time frame for this A-95 review elapsed on March 29, 1980. The time frame for such a review commences when an application is received and the application for the replacement project was received on April 9, 1980.

REFERENCES

1/ Replacement of the VAMC, Minneapolis, MN: An Overview. VACO, April 3, 1980.

2/ Annual Report of the Administrator of Veterans Affairs, for Fiscal Year 1978.

3/ Veterans' Administration Response to The Study of Health Care for American Veterans: A Report. Submitted to the U.S. Senate. September 22, 1977.

4/

Section II

COMMUNITY INPUT

A. Community Input

The Metropolitan Health Board conducted the A-95 Review of the replacement project by assigning eleven of its members to examine the project in depth. This Project Review Committee met on six occasions with representatives of the Minneapolis VAMC. These meetings were all public meetings at which any interested person could attend.

The Health Board conducted a public hearing on April 30, 1980 at which time the Minneapolis VAMC presented a description of its replacement project to the entire Health Board, the Project Review Committee submitted its Report to the Board and members of the public were invited to speak. Approximately 200 people attended that Hearing.

Exhibit #4 is a list of people who spoke at the Hearing. Because of the deadlines by which this document must be forwarded to other agencies and Congress, the comments received at the Public Hearing are included as Exhibit #6.

Exhibit #5 contains copies of editorials discussing this project in Minneapolis newspapers.

Exhibit #7 contains copies of letters received by the Health Board on this project. The nature of the comments of those who spoke at the Hearing fall into two general categories. First are those who support the project in its entirety as originally submitted. The second category are those who feel the Federal Government has a "double standard" with respect to review of capital expenditures for hospitals and/or those who think this particular expenditure is not necessary.

Section III

NEED FOR THE REPLACEMENT OF THE MINNEAPOLIS VAMC

A. Description of the Replacement Project

B. Analysis of Demographic Data, VAMC Utilization data, and Other Statistical Information

C. Relationship with the University of Minnesota Hospitals and Clinics

D. The 120-Bed Nursing Home

E. Discussion of Alternatives

A. Description of the Replacement Project

1. Overview

The Minneapolis VAMC is one of 172 VAMCs in the U.S. It is a 730-bed hospital providing primary, secondary, and tertiary care in medical, surgical, and short-term psychiatry services to eligible veterans. The primary service area of the Minneapolis VAMC is defined in Washington by the VACO and includes counties in Minnesota, Wisconsin and Iowa. Figure 3 on page 19 illustrates the primary service area of the Minneapolis VAMC. Its tertiary referral service area includes the primary service areas of the Minneapolis, Sioux Falls, and Fargo VA hospitals. Figure 3 also illustrates the service areas of those hospitals.

The present Minneapolis VAMC consists of a complex of buildings located in south Minneapolis. Exhibit 1 at the end of this report presents a graphic overview of the existing buildings.

In 1972 the VACO began a five-year facility planning process for each of the VAMCs in the 28 VA Medical Districts in the U.S. This process required each VAMC to identify construction needs commensurate with their program requirements and medical mission.

Concurrently, VACO planning staff developed guidelines to be used in evaluating physical plants (Space and Functional Deficiency Identification System - SFDI) in the planning process described above. These guidelines involved a technical assessment in three general areas:

a) building condition;
b) utility systems, and
c) ability to meet codes and standards.

Use of these guidelines resulted in a VACO finding that the Minneapolis VAMC was among the three most deficient physical plants of all VAMCs. The A-95 application describes these plant deficiencies in greater detail in Section Seven.

As a result of the five-year planning effort and the technical plant assessment, a decision was reached to replace the facility. The new building will accommodate all inpatient services, outpatient clinics, diagnostic and treatment services. Patient care units will be arranged in two towers with three nursing units per tower or six nursing units per floor. The nursing units will be either 30-bed or 40-bed units with the exception of critical care units.

Note: There is some discrepancy about what the actual configuration of the building will be. The description above is from the Master Plan Report prepared by Ellerbe Architects at the request of the VACO. Its Report reflects the views of Ellerbe, and not the VA until formally adopted by the VACO. The description of the building configuration in the A-95 application results from an earlier schematic version developed by the Ellerbe firm.

best copy available

2. The Proposed 725 Hospital Bed Replacement

It is necessary to clearly understand the mix of beds by service and the method by which estimates of beds needed by service were derived. The basic method used by the VA was the GAO model of determining bed demand requirements. In 1977 the GAO was requested by the Senate to make a comprehensive evaluation of the process used by the VA to determine the bed size of replacement hospitals.

The GAO submitted its report[1] in May of 1978. The report included a suggested model to be used in determining the appropriate total size and service bed mix of VA hospital replacement projects. The model determines acute care bed requirements by comparing the medical record of each VA patient discharged during a specified fiscal year and adjusting the VA patient's length of stay to conform to the length of stay of a comparable (age, sex, diagnosis) patient in a non-federal community hospital. This adjustment assumes that the length of stay in VA acute care beds is longer than necessary. The adjustment results in the "beds required" for the year in which patient discharges are compared. The model then projects future acute bed requirements for a given year based on changes in the age distribution of veterans.

An example from the A-95 application will illustrate the method. (The reader can compare page A-2 of Exhibit 7-2 of the A-95 application.)

1. Total VA hospital days in 1977 for patients between the ages of 25 and 44 who were discharged from the Internal Medicine Service were 5,504 patient days.
2. The GAO patient record match indicated that 4,047 days were appropriate as acute care days and 457 days appropriate as non-acute.
3. At 85 percent occupancy, this age group would require 13.04 acute care beds.
4. This age group's population change between 1977 and 1985 resulted in a ratio of 0.92 (1977 population divided by 1985 population).
5. Acute care beds required in 1985 in Internal Medicine by patients between 25 and 44 is then 0.92 times 13.04 or 12 acute care beds.

There are two important assumptions in the model. They are that the average length of stay for the age group will be the same in 1985 as the 1974 adjusted length of stay, and that the admission rate will also remain the same. The adjustment of VA length of stay to the non-federal length of stay was based on 1974 data from the Commission on Professional and Hospital Activities (CPHA). CPHA data for 1977 is now available.

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[1] Inappropriate Number of Acute Care Beds Planned by VA for New Hospitals. Report by the Comptroller General of the United States, May 1978.

The application of the GAO model to this project used 1977 discharge data. The VAMC reported a total of 232,919 patient days of which 153,916 (66 percent) were determined to be acute patient days after the patient record adjustment was made.

The next step in the model allocates the portion of hospital days of care deemed to be inappropriately provided in acute care beds to lower levels of care. Lower levels of care are defined as intermediate care, rehabilitation, non-acute psychiatric care, nursing home care and outpatient care. That portion of hospital days allocated to non-acute bed status is done on a percentage basis. In the case of the Internal Medicine Service non-acute days are distributed to lower levels of care:

. Intermediate	14%
. Convalescent	12%
. Nursing Home	24%
. Outpatient	50%

The only adjustment by the GAO model to non-acute days is projecting future non-acute days based on population changes.

One problem with this model is the combination by the VA of acute care beds and non-acute care beds within an acute care setting. The combination of non-acute beds and acute beds within the acute care facility may have the effect of removing any substantial decrease in the existing bed complement of a facility to be replaced.

This occurs because the non-acute hospital patient days subtracted from the total hospital patient days are added back-in in the form of non-acute beds. The only decrease in a total bed complement would come from either the change in the age structure of the population or those non-acute patient days allocated to outpatient visits. Outpatient visits is the one level of care that does not require a non-acute bed. A flow chart of the modeling technique is attached as Exhibit 3.

Table XIV presents the number and types of beds proposed as discussed in the A-95 application of the Minneapolis VAMC and other documents it has submitted.

Table XIV
Comparison of Hospital Beds Proposed by Service, By Source: Minneapolis VAMC

	VAMC Proposed	Architect Schematic[1]	GAO Model
ACUTE			
Internal Medicine	222	252	227
Rehabilitation	12		12
Hemodialysis	10		0
CICU		(6)	
MICU		(6)	
Surgery	277	257	277
Neurosurgery		(40)	
Orthopedic		(74)	
SICU		(13)	
TICU		(10)	
Neurology[2]	44	44	38
GRECC[3]	10	10	
Psychiatry	60	60	65
Chemical Dependency	30	30	
Subtotal: Acute	665	653	619
NON-ACUTE			
Intermediate	30	30	25
Convalescent	0	0	32
Rehabilitation	30	30	29
Psychiatric	0	0	31
Nursing Home	120	120	40
Subtotal: Non-Acute	180	180	157
Total Beds	845	833	776

[1] Master Plan Report, Minneapolis VAMC. Ellerbe Associates, Inc., Bloomington, MN. March 28, 1980.

Note: "Comments and views herein (Master Plan Report) are those of the author (Ellerbe) and do not reflect the views of the Veterans Administration unless adopted by a proper official of the agency. The information herein should not be used for quotation or attribution without this disclaimer."

The Master Plan Report was submitted by the VACO to the staff of the Senate Veterans Affairs Committee on April 8, 1980.

[2] Neurology includes six (6) long-term beds.

[3] Geriatric Research, Education, and Clinical Center

The major differences between the GAO model and what is proposed by the VAMC is that the replacement project includes:

- a 10-bed hemodialysis unit
- a six-bed long-term care neurology unit
- a 10-bed Geriatric Research, Education and Clinical Center unit
- no convalescent beds are proposed
- a 120-bed nursing home (vs. 40 beds) unit
- no non-acute psychiatry beds
- a 30-bed chemical dependency unit.

3. Primary Service Area of Minneapolis VAMC

The primary service area of the Minneapolis VAMC consists of counties in Minnesota, Wisconsin and Iowa. Figure 3 on page 19 illustrates that PSA.

Figure 4 on page 20 illustrates the percentage of the patients from the Minneapolis VA's primary service area and the percentage from the Seven-County Metropolitan Area. The figure shows that the percentage of patients at the hospital who reside in the primary service area is increasing. This occurs at the same time that discharges (excluding dialysis) are decreasing. Figure 4 also illustrates that the number of patients from the Seven-County Metropolitan Area constitute a stable pattern of 51 to 52 percent of the hospital's patients.

The numbers discussed above are set forth:

	Discharges[1]	% from PSA	% from Metro Area
1976	16,557	85.6%	51.6%
1978	15,880	86.7	51.0
1979	15,312	87.6	52.6

[1] Excludes one-day dialysis visits.

Figures 5 through 8 on pages 30 through 33 illustrate the geographical origin of patients and patient days for 1976 and 1978. The actual numbers for 1978 are:

	Patients	Patient Days
Seven-County Metro Area	51.0%	50.1%
Other Minnesota	33.4	33.2
Wisconsin	7.6	7.4
South Dakota	2.8	3.6
North Dakota	2.4	2.5
Iowa	1.4	1.7
All Other	1.4	1.6

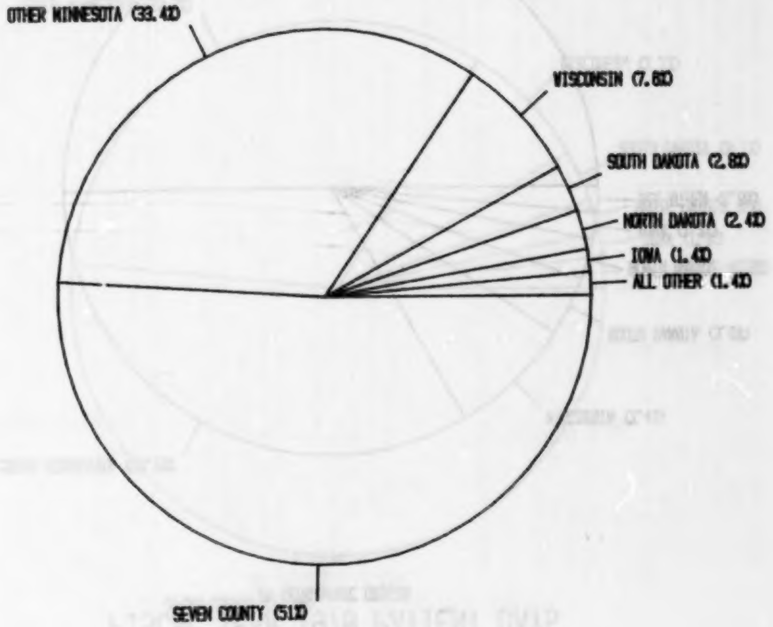
B. Analysis of Demographic Data, VAMC Utilization Data and Other Statistical Information

There are three central concepts to keep in mind when reviewing the information and data on the proposed Minneapolis VAMC 725 hospital bed replacement project.

The first concept involves the VACO use of the modeling technique developed by the General Accounting Office (GAO) to determine the number of "required beds" at the Minneapolis VAMC site. An integral part of that concept is the fact that the VA includes within the definition of "hospital beds" both acute and non-acute hospital beds. The proposed 725-bed hospital replacement at the Minneapolis site includes 60 non-acute beds and 665 acute beds.

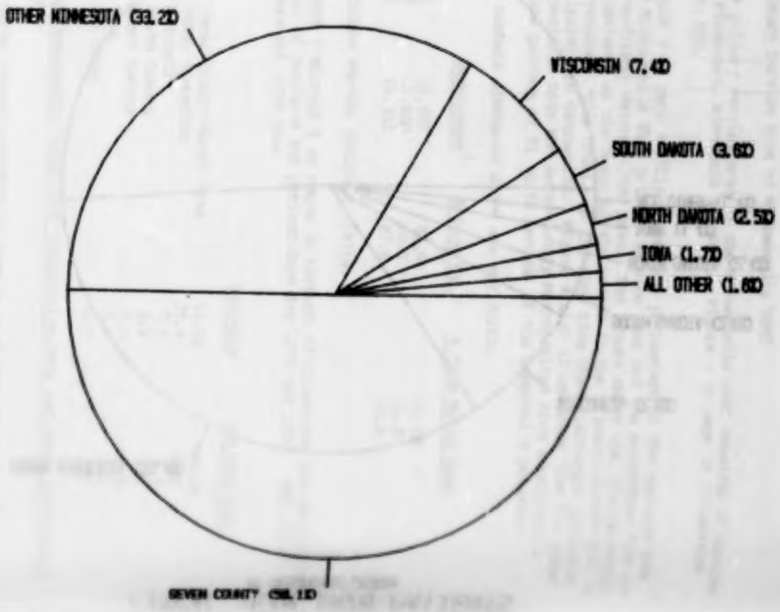
FISCAL YEAR 1978 PATIENTS
BY GEOGRAPHIC ORIGIN

FIGURE 5



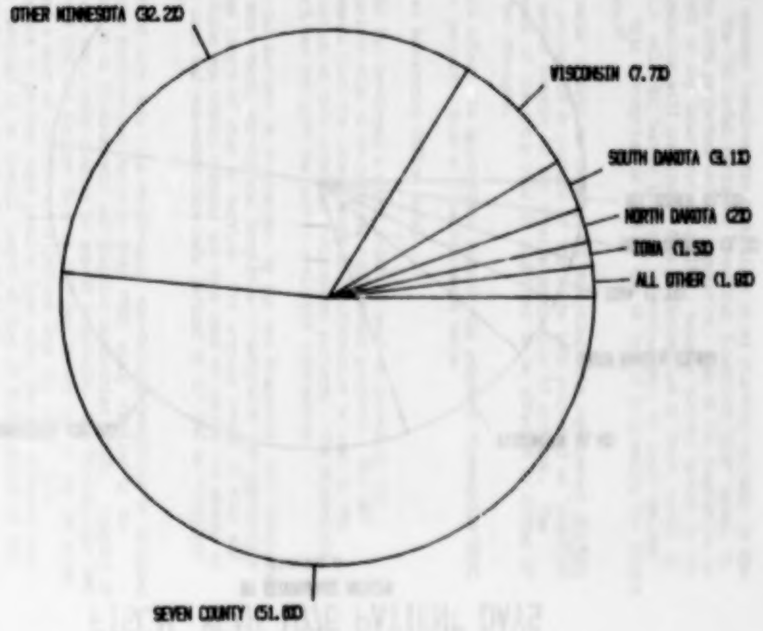
FISCAL YEAR 1978 PATIENT DAYS
BY GEOGRAPHIC ORIGIN

FIGURE 6



FISCAL YEAR 1976 PATIENTS
BY GEOGRAPHIC ORIGIN

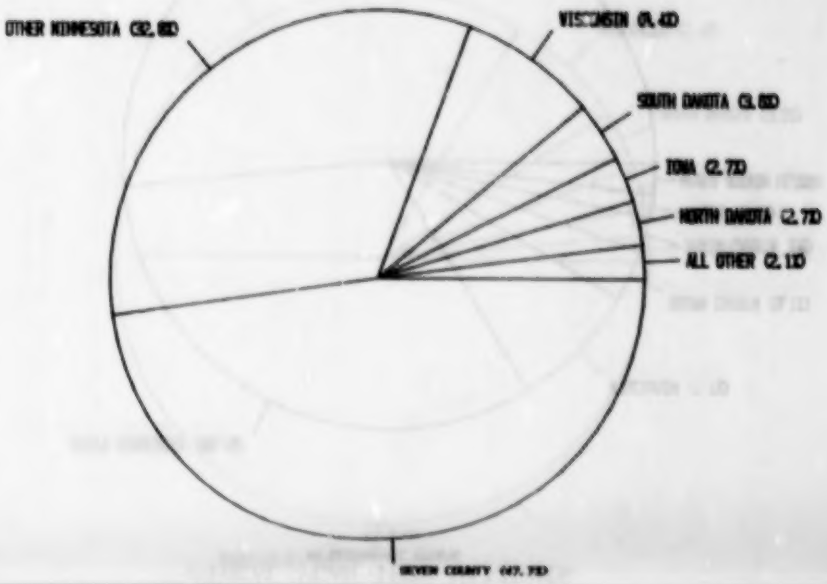
FIGURE 7



FISCAL YEAR 1976 PATIENT DAYS

BY GEOGRAPHIC ORIGIN

FIGURE 8



The second concept involves the population based planning variable in the GAO model. The GAO model estimates "required (hospital) beds" based, in part, on the 1985 projected veteran population. Use of the population in the year 1985 or any later year (e.g. 1995) assumes current trends in the veteran population will continue. A major assumption of these trends is that the U.S. will not become involved in another war; at least another major war. This assumption is used by the VA itself in planning for future health needs.[1]

The third major concept to remember in analyzing this replacement project is that 50 percent to 60 percent of the acute beds projected as "required beds" are needed because of the veteran population 65 and over. The hospital needs of the group over 65 ought not to be affected by either of the first two concepts.

Many factors affect the appropriate size of the proposed Minneapolis VAMC replacement project. Each will be discussed below.

1. General Accounting Office Model

   The GAO has developed a model which is used to determine the appropriate size of VA hospital replacement projects. The GAO recommends that the latest available information be used in the application of this model to replacement projects. The Minneapolis project has not used the latest available information.

   The model matches VA discharges, by age and diagnosis, with discharges from short-term, non-federal hospitals to determine the appropriate average length of stay by service. The average length of stay and population age cohort changes are then used to derive the number of acute care and non-acute care beds defined by the GAO as "required beds."

   Length of stay data from short-term, non-federal hospitals is obtained from the Professional Activity Stay (PAS) study compiled by the Commission on Professional and Hospital Activities (CPHA). Lengths of stay are invariably shorter in non-VA hospitals. The Minneapolis VAMC reported 226,984 patient days in 1977 but in its use of the GAO model it used a base of 153,916 acute patient days for 1977. This difference of patient days results from using the PAS adjusted data which resulted in an overall length of stay of 9.39 instead of the Minneapolis actual length of stay of 14.15.

   a. The Minneapolis VAMC used 1974 PAS data for length of stay adjustments. PAS data for 1977 is available and the GAO recommends the latest PAS data available be used in its model. PAS data for 1977 indicates decreased lengths of stay from that reported in 1974 data.

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[1] Present and Future Medical Needs: A Report on the Aging Veteran. Submitted to the U.S. Senate by the V.A., January 6, 1978.

Table XV
Comparison of 1974 and 1977 PAS Data
of Average Length of Stay by Age Cohorts[1]

Age Cohorts	United States 1974	United States 1977	North Central 1974	North Central 1977
-19	4.2	4.2	4.4	4.3
20-34	5.0	4.9	5.4	5.2
35-49	7.3	6.9	7.6	7.3
50-64	9.1	8.7	9.4	9 [illegible]
65+	11.7	11.1	12.1	11.3
All Ages	7.1	6.9	7.3	7.1

[1] Data received by [illegible] staff by telephone call from CPHA. Data includes both male and female and hospitals of all sizes.

Two important points need to be made about the information in Table XV. First, it indicates that length of stay has decreased between 1974 and 1977. Secondly, the data in Table XV is for all patients (men, women and children) in hospitals of all sizes. These two factors (all patients and hospitals of all sizes) tend to lower lengths of stay when compared to lengths of stay for male patients only in hospitals of 500 or more beds. The more appropriate PAS comparisons would have been male patients only in hospitals of at least 500 beds or more. That comparison would more accurately reflect the GAO model. Staff was unable to obtain such data from the CPHA.

However, other data exists which confirms that lengths of stay for males only in hospitals of 500 beds or more continue to decrease, especially for male patients over 65. Tables XVI and XVII present that data.

Table XVI
Average Length of Stay in U.S.
for Male Patients Discharged from Hospitals
of 500 Beds or More

Age	1976	1977	1978
-15	5.5	5.9	5.7
15-44	8.1	8.0	7.8
45-64	10.3	10.3	9.9
65+	12.8	12.3	11.9
All Ages	9.4	9.3	9.1

Source: Inpatient Utilization of Short Stay Hospitals by Diagnosis, U.S., 1976, 1977 and 1978. National Center for Health Statistics, Series 13, Numbers 37, 41 and 46.

Table XVI indicates a continued decrease in length of stay for male patients only in hospitals of 500 beds or more. Table XVII shows a decrease between 1976 and 1977, with an increase in 1978, for such hospitals in the North Central region of the U.S.

Data similar to the above is not available in the same format for the years 1974 and 1975. The data strongly suggest that if the GAO model were recalculated using 1977 PAS data, that on the average, the lengths of stay derived for the Minneapolis VAMC would be lower than those from 1974 data.

Table XVII
Average Length of Stay in North Central[1] U.S.
for Male Patients Discharged from Hospitals
of 500 Beds or More

Age	1976	1977	1978
-15	5.5	5.5	5.2
15-44	8.3	8.0	8.1
45-64	10.5	10.2	10.3
65+	13.3	11.2	11.6
All Ages	9.6	9.0	9.2

[1] North Central States include Michigan, Ohio, Illinois, Indiana, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas.

Source: Inpatient Utilization of Short Stay Hospitals by Diagnosis, U.S., 1976, 1977 and 1978. National Center for Health Statistics, Series 13, Numbers 37, 41 and 46.

The data for North Central U.S. and U.S. may even be overstating appropriate lengths of stay in favor of the Minneapolis VAMC. In 1976 and 1978, 98 percent of all patients came from Minnesota, Wisconsin, Iowa, North and South Dakota.

Table XVIII illustrates the length of stay for those five states for Medicare beneficiaries (male and female) discharged from hospitals of all sizes.

Table XVIII
Length of Stay for Patients 65 and Over
from Selected Areas

	1974	1975	1976	1977
U.S.[1]	11.7	NA	NA	11.1
N.C.[1]	12.1	NA	NA	11.3
Minnesota[2]	11.1	10.9	10.5	10.0
Wisconsin[2]	11.9	11.4	10.9	10.7
Iowa[2]	11.2	11.2	10.8	10.0
N. Dakota[2]	10.5	10.2	9.9	9.5
S. Dakota[2]	10.0	10.0	9.7	9.1

[1] CPHA data (see Table V).
[2] Source: Health Care Financing Review, Summer 1979, Includes discharges from hospitals of all sizes.

The trend in all of the data in Tables XV to XVIII is decreasing lengths of stay for those patients either over 65 or male patients (including those over 65) discharged from hospitals of

500 beds or more. The conclusion that is drawn is that use of 1977 PAS data instead of 1974 PAS data could result in shorter lengths of stay for VAMC patients and, therefore, fewer acute care beds being needed.

b. A second major element in the GAO model is the concept of discharge rate. The use of discharge data in the model assumes that the discharge rate will remain constant by age group between the data year and the year in which bed demand is projected. This is probably why the GAO recommends the use of the average of the three most recent years' discharges.

Minneapolis VAMC discharges and discharge rates are set forth in Table XIX.

Table XIX
Minneapolis VAMC Discharge Rates[1]

Year	Discharges	Population	Discharge Rate
1976	16,557	535,675	30.91
1977	16,471	539,804	30.51
1978	15,880	545,333	29.12
1979	15,312	547,117	27.99

[1] Excludes one-day dialysis.

Table XIX indicates an important trend. Although the veteran population was increasing between 1976 and 1979 the number of discharges was decreasing. This results in a steady trend of decreasing discharge rates.

The meaning of discharge rates and their decline at the Minneapolis VAMC is shown in Table XX. The only year for which Health Board staff has age-specific discharge data is 1977. Thus to determine age specific discharge rates for 1978 and 1979 an assumption was made that the distribution of discharges by age would be similar in 1978 and 1979 to what it was in 1977. This assumption permits a calculation of age-specific discharge rates for 1978 and 1979 which can then be used to project the number of admissions for 1985 just as the VA/GAO model did, but at the same time illustrate how declining discharge rates affect the beds that are needed based on projected admissions.

Table XX
1985 and 1990 Projected Number of Admissions
Based on 1977, 1978 and 1979 Discharge Rates

Discharge Year	Projected Admissions of 1985	Projected Admissions of 1990
1977[1]	19,360	20,843
1978[2]	19,047	20,331
1979[2]	17,799	19,053

[1] VAMC projections based on 1977 discharge rate.
[2] MHB projections based on 1978 and 1979 discharge rates.

Note: The projected number of admissions in 1985 and 1990 exceed those (discharges) in 1976 to 1979 because of the substantial increase in veterans over 65 and the greater use of hospitals by that age cohort.

The conclusion drawn by staff is that application of the GAO model to a VAMC replacement project determines the size of the VAMC. Two important variables in the GAO model are length of stay and discharge rate. Trends of these two variables are important enough that the latest data available should be used. More recent data than that used in the Minneapolis project is available and should, therefore, be used.

The GAO model uses actual patient records matched by age and diagnosis to determine the appropriate lengths of stay. Metropolitan Health Board staff does not have access to that information and thus cannot provide an alternative estimate of "beds required" by using the GAO model.

1. Changing Population Structure of Veterans

The size of the Minneapolis VAMC proposal is based on a projected veteran population in 1985. 1985 is one year prior to scheduled completion of the new hospital building. VA Central Office estimates of the veteran population indicate a decreasing overall population but one which is increasing in age.

The age structure of the veteran population in any one year will affect the demand for hospital services. This change in age structure over time is demonstrated in Table XXI. Table XXI uses the GAO model changing only the number of veterans in each age cohort by use of VACO population estimates. The previous comments on use of the GAO model are equally applicable to the Table below. Its sole purpose is to illustrate how the changing age structure affects the GAO bed demand calculations.

Table XXI
Bed Demand Changes
Because of Changing Age Structure of Veterans

Age	1985 Population	1985 Required Beds	1990 Population	1990 Required Beds	1995 Population	1995 Required Beds
0-24	30,824	18	41,430	24	53,343	31
25-44	210,353	61	163,231	47	114,187	33
45-54	113,676	80	137,802	98	166,145	118
55-64	103,473	148	64,211	92	61,899	89
65+	82,423	312	110,180	417	106,079	401
		619		678		672

Table XXI illustrates that 50 percent of the acute care beds would be required due to those 65 and over in 1985. In the decade of the 1990s this percentage rises to 60 percent. Figure 9 illustrates the percentage of acute beds needed by service for those over 65 in 1977, 1985 and 1990.

4. VACO Hospitalization Priorities

Veterans who are entitled to VA hospital care must also meet eligibility criteria for hospital care. The general eligibility criteria are:

1) a veteran with a service connected disability and the hospitalization is for the service connected disability; or

2) a veteran with a service connected disability and hospitalization is for a non-service connected health problem if:

    a) the veteran is receiving a disability compensatoin (or military retirement in lieu of such compensation) or

    b) such health problem is associated with the service connected disability; or

3) 65 years of age or older; or

4) a Congressional Medal of Honor winner; or

5) a veteran receiving a pension; or

6) a veteran unable to pay the costs of hospitalization.

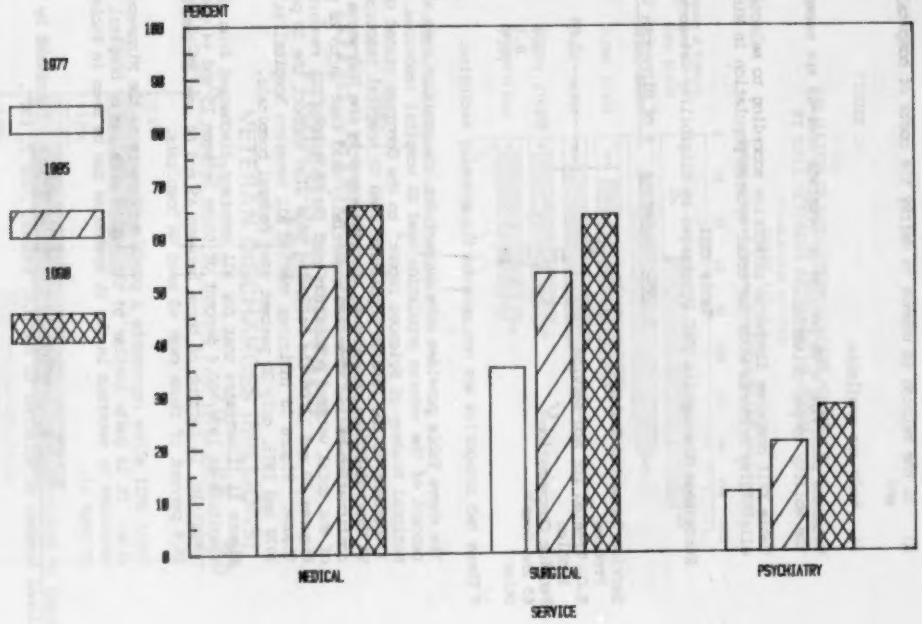
First priority for admission is given to veterans with service connected disabilities. Second priority for admission is given to veterans with service connected disabilities who need hospital treatment for an unrelated condition. Third priority for admission is for veterans without a service connected disability if:

1) hospitalization is necessary; and

FIGURE 9

% ACUTE BEDS NEEDED FOR PATIENTS 65+

SOURCE: GAO PROJECTIONS FOR MPLS VAMC



2) if the veteran is unable to defray the costs of hospitalization; and

3) beds are available.

Veterans receiving a VA pension or veterans over 65 are exempt from the ability to pay criterion.

Table XXII compares discharge categories according to selected eligibility criteria with the total veteran population in Minnesota.

Table XXII
Percentage Minneapolis VAMC Discharges by Eligibility Category

	% VAMC Discharges	% of Minnesota Veterans
Service Connected Health Problem	8%	7.6%
S.C. Treated for Non-service Problem	22	
Pension Compensation[1/]	24	3.4
65 and Over[1/]	27	8.1
Other	19	79.9

[1/] These two categories are not necessarily mutually exclusive.

The above Table provides some support for the position that about 20 percent of the veteran population used VA hospital resources. The National Academy of Sciences report[1] to the Congress stated that 10-13 percent of the veteran population used VA hospital resources. The VA Central Office response to that statement by the NAS was a partial confirmation of it. The VACO essentially said that up to 20 percent of the total veteran population used the VA's hospital resources. Figures 10 and 11 on the following page also support the 20 percent figure. Figure 10 indicates that of all veterans hospitalized between 1970 and 1973, only 20 percent used Federal hospitals.

Figure 11 illustrates that for all veterans discharged from all hospitals in 1976, 10.6 percent of those between 15 and 44 used VA hospitals, 14 percent of those between 45 and 64 used VA hospitals and 18.6 percent of those over 65 used VA hospitals.

Table XXII above represents a profile of users at the Minneapolis site. It is quite similar to the nation-wide use of hospital resources by veterans in the VA system as can be seen in Table XXIII on page 43.

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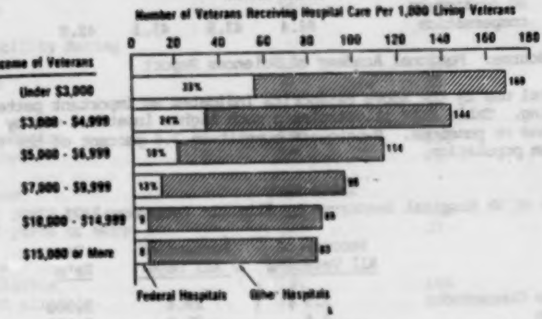
[1] Study of Health Care for American Veterans: A Report. Submitted by the National Academy of Sciences to the U.S. Senate, June 7, 1977.

FIGURE 10

UTILIZATION OF SHORT TERM GENERAL HOSPITALS BY MALE VETERANS ACCORDING TO INCOME

Annual Average 1970-1973

CHART III-h



SOURCE: National Health Interview Survey, DHEW National Center for Health Statistics

FIGURE 11

TOTAL VETERAN DISCHARGES FROM U.S. HOSPITALS

1976

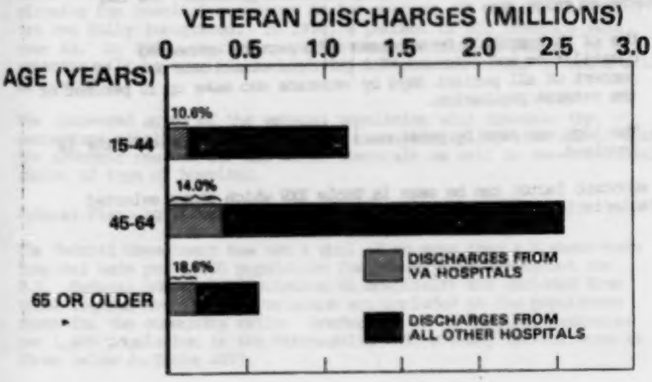


Table XXIII
Percent Distribution of Hospital Patients
in All VAMCs on Census Day

	1978	1977	1976	1975
Service Connected	28.6	29.3	27.2	29.1
Pension	26.5	26.5	27.0	27.6
Non-service connected, no pension or compensation	44.4	43.8	45.3	42.9

Source: National Academy of Sciences Report

Hospital use by the above categories indicates an important pattern is emerging. Table XXIV illustrates a much higher inpatient use by veterans on pensions. Pensioners constitute 3.4 percent of the total veteran population.

Table XXIV
Use of VA Hospital Resources by Eligible Veterans, 1975

	Percent of All Veterans	Percent of All Days	Use Rate
Service Connected	7.5	29.4	3,900
Pension	3.4	27.8	8,100
Non-service Connected, no pension or compensation	89.2	42.4	500

Source: National Academy of Sciences Report

Inpatient days per 1,000 by veterans on compensation is half that of those veterans on pension. Pensioners' use rate is sixteen times that of veterans who have neither compensation nor pension. The two patterns emerging are:

1. Use of VA hospitals by veterans with service connected disabilities and veterans with pensions constitute about 57 percent of all patient days by veterans who make up 10 percent of the veteran population.

2. The high use rate by pensioners indicates an economic factor is involved.

The economic factor can be seen in Table XXV which shows selected characteristics of veterans.

Table XXV
Selected Characteristics in 1975 of Veterans Using All Hospitals Between 1964 and 1975

	Non VA and/or VA	VA Only
Health Insurance in 1975		
Yes	82%	58%
No	18	42
VA Disability Rating		
Yes	23%	45%
No	77	55
Race		
Caucasion	85%	69%
Other	15	31
Education		
12 years or less	41%	63%
12 years or more	59	37
Medicare		
Eligible	10%	14%
Not eligible	90	86

Source: National Academy of Sciences Report

Thus the veteran using VA hospital resources compared to his/her veteran counterpart using non-VA hospital resources is less likely to be insured, more likely to have a disability rating, more likely to be a minority and less likely to be a high school graduate.

The percent eligible for Medicare in 1975 compared to the changing age structure of the veteran population again illustrates the problem of planning for hospital resources in two systems (VA and non-VA) which are not fully integrated. In 1970, 8 percent of all veterans were over 65. By 1990, population projections indicate 21 percent of all veterans will be over 65; and by 2000, 27 percent of all veterans will be over 65.

The increased aging of the veteran population will increase the percentage eligible for Medicare and this eligibility will affect both the economic reasons for use of VA hospitals as well as the individual choice of type of hospital.

5. Federal Planning Efforts

The Federal Government has set a goal of no more than 4.0 short-term hospital beds per 1,000 population for communities throughout the U.S. Federal hospitals (including VA hospitals) are excluded from these figures even through veterans are included in the population count for the community ratio. Comparison of VA hospital resources per 1,000 population in the Minneapolis VAMC primary service area is shown below in Table XXVI.

Table XXVI
Minneapolis VAMC Bed Ratios per its HA Population at a Total of 665 Acute Hospital Beds[1]

Year	Veteran Population	Beds Per 1,000	20% Veteran Population	Beds Per 1,000	4 Beds Per 1,000	Percent Veteran Population
1979	547,117	1.2	109,423	6.1	4.0	30%
1985	540,749	1.2	108,150	6.2	4.0	31
1990	516,854	1.3	103,371	6.4	4.0	32
1995	501,653	1.3	100,331	6.6	4.0	33
2000	466,740	1.4	93,348	7.1	4.0	36

[1] The VA is proposing 725 hospital beds, of which 40 are non-acute and 665 are acute according to VA definition.

While the VA system stipulates it must plan its hospital resources for all veterans, the figures above compared with those that indicate only 20 percent of veterans use VA hospitals, indicate the size of the hospital may not be documented by the demonstrated need if the Federal goal of four short-term beds per 1,000 is applied as a criterion. Non-VA hospital use by veterans demonstrates that not all veterans use VA hospitals. Thus the range of 1.3 to 1.6 beds per 1,000 is not an accurate measure of resources. The more accurate measure rests somewhere between the 20 percent and 40 percent figures in the above Table.

6. Length of Stay

One of the reasons for the high number of patient days experienced at the Minneapolis VAMC even though not all veterans use the hospital is the length of stay at the hospital.

Table XXVII
Length of Stay at the Minneapolis VAMC

	1979	1978	1977
Total	13.8	14.0	14.2
Surgery	12.8	12.3	12.5
Psychiatry	24.8	27.3	26.1
Medicine	12.6	13.5	13.9
Medicine	11.4	12.7	12.9
Neurology	15.0	14.6	14.8
Rehabilitation	32.3	20.4	34.0

The application of the GAO model to this VAMC's 1977 data resulted in the overall 1977 length of stay being adjusted from 14.2 to 9.4 for purposes of determining acute care beds required in 1985.

7. The Effect of Discharge Rates and Length of Stay on the Number of Acute Care Beds Needed

Tables XXVIII to XXX show the cumulative effects of using more recent length of stay figures and more recent discharge rate data.

Tables XXVIII and XXIX use Metropolitan Area length of stay by age groups and the VA's estimated admissions for 1985 and 1990. Those Tables indicate an acute care bed need of 586 to 634 when only length of stay is adjusted.

Table XXVIII

Calculation of 1985 VA Acute Bed Demand Using Metropolitan Are Length of Stay and VA 1977 Discharge Rate[1]

Age	1985 Estimated Admissions	Average Length of Stay	Patient Days	Average Daily Census	Beds At 85% Occupancy
0-24	772	8.3709	6,462.34	17.7	20.83
25-44	2,419	8.3344	20,160.91	55.24	64.98
45-54	2,881	8.3741	24,125.78	66.10	77.76
55-64	5,018	8.8844	44,581.92	122.14	143.70
65+	8,470	10.1989	86,364.68	236.67	278.44
			181,715.63	497.85	585.7

[1] Metropolitan Length of Stay for males only, 21 and over.

Table XXIX

Calculation of 1990 VA Acute Bed Demand Using Metropolitan Area Length of Stay and VA 1977 Discharge Rate[1]

Age	1985 Estimated Admissions	Average Length of Stay	Patient Days	Average Daily Census	Beds At 85% Occupancy
0-24	1,038	8.3709	8,688.99	23.80	28.01
25-44	1,877	8.3344	15,643.67	42.86	50.42
45-54	3,492	8.3741	29,243.36	80.12	94.25
55-64	3,114	8.8844	27,666.02	75.80	89.17
65+	11,322	10.1989	115,472.9	316.36	371.19
				538.94	634.04

[1] Metropolitan Length of Stay for males only, 21 and over.

Table XXX

Calculation of 1985 VA Acute Bed Demand Using Metropolitan Area Length of Stay and VA 1979 Discharge Rate[1]

Age	Estimated Admissions	Average Length of Stay	Patient Days	Average Daily Census	Beds At 85% Occupancy
20-24	631	8.3709	5,282	14.47	17.02
25-44	2,263	8.3344	18,861	51.67	60.79
45-54	2,796	8.3741	23,414	64.15	75.47
55-64	4,369	8.8844	38,816	106.34	125.11
65+	7,740	10.1989	78,944.9	216.3	254.46
					532.85

[1] Metropolitan Length of Stay for males only, 21 and over.

Table XXX uses the VAMC's 1979 discharge rate and the Metropolitan Area's length of stay. These tables indicate an acute care bed need range of 533 to 634 compared to the GAO estimate of 619. These tables do not take into account the non-acute care bed distribution nor the units proposed by the VAMC over and above the GAO model. Thus the comparison should be with the 619 figure, not the 725 figure. However, the manner in which the VA/GAO model works is that the fewer acute care beds projected as needed the more non-acute beds are projected as needed (although not on a one-to-one basis).

Another assumption in the VA/GAO model is that the veteran population reaching 65 in 1985-1990 will use the VA hospital at the same rate as veterans over 65 used the hospital in 1977. It is impossible without a survey to determine the preferences of those veterans now approaching 65 and whether they would use the VA hospital at a greater or lesser rate than those now over 65 use the hospital.

However, Figure 11 which examines all veteran discharges from all hospitals in 1976 indicates that 14 percent of veterans between 45 and 64 use VA hospitals while 18.6 percent over 65 use VA hospitals. If that trend continued then the percentage of veterans over 65 using VA hospitals in the future would decrease by 25 percent. (This should not be confused with the Use Rate of those over 65.) The 25 percent figure is calculated: (100 - 14.0 ÷ 18.6). If that trend held true then the number of beds needed at the Minneapolis VAMC using 1979 VAMC discharge rate, GAO ALS and adjusting the 65 and over admissions is shown in Table XXXI.

Table XXXI
Calculation of 1985 VA Acute Bed Demand
Using VA/GAO Length of Stay, 1979 VA Discharge Rate,
and Adjusting the Percentage of 65+ Estimated Admissions

Age	1985 Estimated Admissions	VA/GAO ALS	Patient Days	Average Daily Census	Beds at 85 Percent Occupancy
-24	631	7.2	4,543.2	12.45	14.64
25-44	2,263	7.82	17,696.7	48.48	57.04
45-54	2,795	8.66	24,213.4	66.34	78.05
55-64	4,369	9.20	40,194.8	110.12	129.56
65+	5,805	11.42	66,293.1	181.63	213.68
					492.97

Staff feels that Table XXXI is the single most important table in this discussion on the effects of length of stay and discharge rates. It changes only two variables, both of which are strongly supported by independent data from the VA itself. Discharge rates have decreased since 1977 as documented by the Minneapolis VAMC's data. This is strong inferential data to indicate that those veterans reaching 65 in the decade of the 1980s may not use VA hospitals as frequently (percentage-wise) as their veteran counterparts who reached the age of 65 in the decade of the 1970s.

The 25 percent adjustment to the projected admissions of those over 65 is supportable by data other than that in Figure 11. Analysis of the Minneapolis VAMC's 1977 age-specific discharge data and data for all male discharges from all hospitals in 1978 and 1979 indicates inferential support that those veterans reaching 65 in the 1980s may not use VA hospitals as frequently (percentage-wise) as those who were 65 and over did in the 1970s.

Table XXXII illustrates the discharge rates for those over 65 and those between 45 and 64 at the Minneapolis VAMC and at all hospitals (male patients only) in the U.S. and in the North Central U.S.

Table XXXII
Comparison of Discharge Rates for Patients over 65
and Patients Between 45 and 64
at the Minneapolis VAMC and All U.S. Hospitals
(Male Patients Only)
for the Years 1977 and 1978

		Minneapolis VAMC[1]	All U.S. Hospitals	N. Central Hospitals
1977	65+	102.76	396.9	425.5
	45-64	35.87	195.2	222.2
1978	65+	NA	412.1	444.2
	45-64	NA	191.9	221.6

[1] Discharge rate for acute beds only

As would be expected (because of increasing age), there is approximately a two-fold increase in discharge rates for those over 65 compared to those between 45 and 64 when the data for U.S. and N. Central hospitals is examined. However, the local VAMC indicates almost a three-fold (2.865) increase.

Two points can be inferred from the data in Table XXXII. It is additional confirmation of the premise that only 20 percent of veterans use the VA system (i.e., 102.76 ÷ 396.9 = 25.9% and 195.2 ÷ 35.87 = 18.4%). Secondly, if the two-fold increase in discharge rates between those 65+ and those 45-64 is applied to the VAMC discharge rate for those 45 to 64, the result is about 75 percent of the 1977 discharge rate for those 65 and over at the Minneapolis VAMC. Thus one of three things is occurring:

a) The Use Rate of veterans between 45 and 64 is less than that of the total male population between 45 and 64. This is quite unlikely.

b) Veterans between 44 and 65 prefer non-VA hospitals but on reaching 65 begin to use VA hospitals more often. This is more likely than (a) above but obviously physician and hospital use patterns are created for those between 45 and 64 and are not likely to change (even for economic reasons) when the individual reachs 65 years of age.

c) Veterans who will turn 65 in the 1980s will not use the VA hospital system as frequently as those 65 and over did in the 1970s.

Staff feels that the third alternative is the more likely explanation than the other two.

A "worst case" situation would be if the rate of admissions does not increase as projected by the VA. Table XXXIII shows what the effect would be if the projected admissions of the VAMC fail to materialize.

Table XXXIII
Projected Acute Care Bed Requirements
Using 1977, 1978 and 1979 Discharges
and the VA Proposed Length of Stay[1]

Year	Actual Discharges	Patient Days[1]	Average Daily Census	Acute Beds Needed[2]
1977	16,471	154,663	424	499
1978	15,880	149,113	409	481
1979	15,312	143,780	394	463

[1] Assumes VAMC length of stay for acute beds.
[2] At 85 percent occupancy.

Table XXXIV summarizes the effects of all of the variables affecting estimated acute care bed need. It incorporates the increasing numbers of those over 65 between 1985 and 2000, the decreasing discharge rate from 1977 through 1979, the difference between the VA/GAO length of stay based on 1974 data and Metropolitan Area 1978 length of stay plus the pattern of VA hospital use of those now over 65 with those between 45 and 64.

Table XXXIV
Acute Bed Need at Minneapolis VAMC

	VA/GAO - ALS			Metro Area - ALS			VA/GAO - ALS 65+ Admission Adjusted			Metro Area - ALS 65+ Admission Adjusted		
	1977	1978	1979	1977	1978	1979	1977	1978	1979	1977	1978	1979
1985	623	606	564	588	571	533	544	529	494	518	502	470
1990	681	663	638	637	619	596	576	559	538	543	527	507
1995	675	653	615	632	614	575	574	553	513	542	525	493
2000	624	607	566	586	569	531	536	519	486	507	491	459
Average			599.75			558.75			507.75			482.25

C. Relationship with the University of Minnesota Hospitals and Clinics

1. Co-location

The issue of co-location, whether it be the VA on the University Hospital campus or the University Hospital on the VA campus was really determined a number of years ago. The University's decision to rebuild its Health Sciences campus set in motion a number of multi-million dollar construction projects now completed and which have resulted in new buildings for the outpatient functions of the University Hospitals, many research activities and classroom space for the Schools of Medicine, Dentistry, Nursing and other allied health programs. To relocate those functions would cost millions of dollars more and, obviously, represents a waste of money recently spent.

The relocation of the VA to the University campus would engender opposition not only from the veterans' community, but also from the neighborhood community within the vicinity of the University Hospitals. They feel the hospital there is already large enough and thus the congestion and land acquisition problems associated with the relocation of the VA to the University site could result in insurmountable objections by the local neighborhood groups.

The real substance of the colocation issue is basically moot in the opinion of staff. It does represent, however, an area that clearly demonstrates that the VA should participate more fully and more actively in the planning process. This is not the same thing as being subject to Certificate of Need review. What it involves is provision of more information on the part of the VA. Staff has been aware of the University's plans to rebuild its hospital for many years while actual confirmation of the VA replacement came only two months ago. Again, it must be noted that the VA did not participate in the Long-Range Hospital Planning process conducted by the Health Board and the area's hospitals. It is felt that the VA should be included in those processes because it does have significant impact on planning for the community's resources because of its roles in patient care, teaching and research.

More active paticipation, as well as earlier indication of major projects or programs under potential development, would benefit the VA as well as the local community.

2. Sharing of Specialized Services

Specialized medical services represent both a heavy capital investment and/or heavy labor-intensive investment in resources. The sharing of such services can have distinct quality and cost results to the consumer and provider alike. Sharing arrangements will also have a significant impact on organizational, financial and total size aspects of an institution.

The VAMC already shares a number of specialized services with the University and other hospitals in this area. The services discussed below offer some potential for further sharing.

a. Stratified Cardiac Care (Open Heart Surgery and Cardiac Catheterization)

Cardiac care services are provided to the individual to prevent, diagnose and treat heart disease. They range from preventive outpatient community services to emergency medical services to highly specialized inpatient treatment.

Growing concern about the cost, efficacy, complexity and changing nature of cardiac services has suggested the need for regionalization of cardiac inpatient services. A regionalized system has been defined by the Inter-Society Commission on Heart Disease Resources of the American Heart Association as consisting of two major elements: (1) area medical facilities organized into a system of varying service capabilities; and (2) public and professional education on heart problems and proper use of the system.

A regionalized system of cardiac inpatient services requires interhospital agreements for the transfer of patients to the facility providing the appropriate level of care, as well as support systems for consultation, educational programs and transportation. It also demands a common regional record system to aid patient transfer and monitoring of the system. But it will also help to ensure adequate caseloads for cardiac care programs while providing safe, economical, accessible care.

The cardiac care services planned for in this area are limited to those provided inpatients in the short-stay, acute care hospital. Concern for the safety, efficacy and cost effectiveness of open heart surgery and cardiac catheterization, two highly specialized procedures, will limit those services to hospitals with the specialized staff, facilities and volume necessary to deliver high quality, economical care to heart patients.

The number of open heart procedures performed at the VA is shown below:

CY 1975	86
1976	78
1977	81
1978	92
FY 1979*	109

*Testimony of Dr. H. Baganz to staff of Senate Veterans Affairs Committee

The VA reports that it performed 255 cardiac catheterization procedures in FY 1979.

The Health Board has adopted a goal of reducing the number of hospitals performing open-heart procedures from 13 to 7 and reducing the number of hospitals performing cardiac catheterization procedures from 13 to 9. The manner in which this reduction takes place is left to the provider community at this time.

Inasmuch as the VA is included in those 13 hospitals providing these services, it should be required to participate with them in the consolidation, merger or phase-out effort. This activity would further not only this area's efforts at improving the cost and quality of these services, but also the VACO's objectives of improving the utilization of VA and community health resources and facilities.

In addition, it should be noted that the volume of open heart surgeries and cardiac catheterization procedures at the VA do not meet the Federal guidelines for community (non-VA) hospitals

b. **Computed Tomography Scanning**

The Metropolitan Health Board reviewed the proposed installation of a whole body C.T. scanner at the VAMC in 1977. It recommended that such installation take place. At that time the local VAMC was only one of six VA hospitals to install the equipment. Based on the Health Board's earlier action, no further comment needs to be made here.

c. **End Stage Renal Disease**

During the past 20 years, the field of nephrology (study of the kidneys) has experienced dramatic technological advancement. Chronic renal disease, marked by slow progression and long duration, may in its least severe form be successfully managed by medication. However, victims of end stage renal disease (ESRD) with irreversible kidney failure depend on renal dialysis or successful kidney transplantation for life and health.

Transplantation, currently considered the preferred or ideal treatment, allows the ESRD patient to return to a more normal life than does chronic dialysis. In addition, transplantation generally imposes less of a financial burden for patients. Patients for whom transplantation is not feasible must rely on an artificial kidney machine for dialysis. Such dependency may create a high-stress emotional environment for both the patient and family. Dialysis cannot be construed as a total "cure" for end stage renal disease.

End stage renal disese services require highly trained personnel and sophisticated equipment. Because of the very high levels of expense associated with these factors, coupled with the relatively low prevalence of ESRD, coordinated treatment networks were established by federal legislation in 1972 to increase planning on a regional basis. Minnesota was included with North Dakota, South Dakota, Upper Michigan and parts of Wisconsin to form ESRD Network No. 7.

ESRD networks are intended to develop comprehensive programs designed to achieve four broad objectives:

1. To provide for the total health care necessary for the treatment of end stage kidney disease;
2. To ensure that all necessary resources are available when and where they are needed;
3. To encourage and support the most appropriate and efficient use of these resources; and
4. To assure quality and contain the cost of treatment for end stage kidney disease.

The VAMC is reporting an increasing number of one-day dialysis procedures. This is the chronic dialysis program. In FY 1979 the VA performed 4,242 such procedures.

It also performed 13 renal transplants in FY 1979. National Guidelines call for 7-14 transplants per year to receive conditional status as a renal transplant center and 15 or more for unconditional status. The University of Minnesota is one of the nation's leading renal transplant centers, if not the leading center. It performs approximately 150 renal transplants per year.

The National Academy of Sciences Report in 1977 recommended that the VA should limit its system of renal transplant centers to six. The VA did not concur with the NAS recommendation of limiting the number but did agree with its premise that the number of centers should be limited by patient care needs and consideration of quality. "The ongoing policy of the VA in this regard is to maintain an appropriate number of such centers, in the best qualified hospitals, with balanced demographic and geographic availability."

Staff concludes that the VA could further its own policy in this area by consolidating the renal transplants at the University. The University is one of the premier hospitals in the nation performing this procedure. The small number of procedures done at the VA should not affect the University's workload. It would also allow the VACO to initiate transplant surgery at other VA hospitals not as fortunate as the local one in being 10 miles from the nation's leading center for such surgery.

The chronic dialysis and home dialysis programs of the VA should continue.

d. Megavoltage Radiation Therapy

Radiation therapy is a medical specialty, directed by physicians with special competence in the use of ionizing radiation, concerned with the management of patients with cancer. These patients may be treated with surgery, chemotherapy, or radiation therapy, individually or in combination.

The goal of radiation therapy is to deliver ionizing radiation to tissues containing, or at high risk of containing, cancerous cells in such a way that these cells are killed while the normal tissues are not damaged extensively. In some instances the treatment is palliative, i.e., it is recognized that the patient cannot be cured. The purpose in such cases is to improve the quality of the patient's life by relieving pain or bleeding or by allowing healing to take place. For example, it may prevent a fracture or reduce the likelihood of local or regional tumor growth. In other instances the treatment is curative in intent. For example, radiation therapy is frequently the treatment of choice in Hodgkin's Disease, early stages of other lymphomas, cancer of the cervix, cancer of the vocal cords, nasopharynx, and many other varieties of head and neck cancer. Cure rates for patients with early stages of these malignancies approach 90 percent. Whether curative or palliative, radiation therapy is used alone or combined with surgery and/or chemotherapy in from 45 to 50 percent of all cancer patients sometime during the course of their diseases.

The Minneapolis VAMC has both a Cobalt 60 and a 4 MeV Linac which it uses in radiation therapy. The University has a cobalt machine and two Linacs: a 4 MeV and a 20 MeV. The replacement project of the University will include new facilities for its Radiation Therapy Center. The location of the 4 MeV Linac at the VA is unaffected by the replacement project because the Linac is housed in the research building at the VA.

Inasmuch as both institutions are embarked on major replacement projects that have concurrent construction and completion timetables, staff feels that the consolidation of this service at the University is appropriate and that the services should be merged upon an agreed-to time frame.

Eighty percent of all such treatments are on an outpatient basis, which minimizes inconveniences to inpatients. Location of the service at the University would mean VA patients would have available to them a wider range of equipment serviced by full time physicists, dosimetrists and radiation therapists.

The volume guidelines used by the Board to examine need for such services include treatment of 300 cases per year per machine with at lest 6,000 treatments per machine per year. These volume gudelines are also those of the Federal government, with which it expects community hospitals to comply.

VA statistics indicate for Fiscal Year 1979, 262 patients were treated with 3,359 procedures. Underutilization of the unit prrovides valid reasons for its transfer to the University.

e. Adult Psychiatric Services

Both the University and the VA operate adult inpatient psychiatric services. This portion of the review concerns itself only with this specific area and does not apply to other psychiatric services or programs. Not affected by this review are the areas of child and adolescent psychiatry, outpatient services, consultation services, emergency services, or older adult services.

At the present time it is the opinion of the Metropolitan Health Board that there is no well-planned, coordinated system for the delivery of mental health services in the Metropolitan Area. Both the University and the VAMC are planning hospital projects whose combined cost is at least one-half billion dollars. The replacement activity offers an excellent opportunity for both institutions to work together to provide leadership in the mental health area. Although psychiatric services are not an intense user of expensive ancillaries, the existence of such services does have an effect on sizes of other hospital support departments.

The University and the VA are both teaching institutions and as such share in clinical and academic faculty as well as teaching relationships and students. The teaching responsibility of the University and the VA need not be jeopardized by this proposal to integrate the adult inpatient services at the VA site.

The Metropolitan Health Board has a guideline of 90 percent occupancy for inpatient psychiatric services. Patient days in the Metropolitan Area have been decreasing since 1976 as have the average number of licensed psychiatric beds. The VA Hospital does meet the occupancy guidelines for psychiatric services, but the University clearly does not.

The 1979 hospital utilization reports show that for adult psychiatry, the VA has an average length of stay (ALS) of 20.2 days and the University has an ALS of 28.3 days. This means that the University has an ALS for adults that is 8.1 days (40 percent) longer than the VA, and 10.8 days (62 percent) longer than the Metropolitan average. The University Hospital has the longest ALS in the Metropolitan Region (not including Anoka State Hospital).

The consolidation of adult inpatient treatment at the VA site could increase the cost efficiency of this service.

Staff of the Metropolitan Health Board recommended:

1) That the VA and the University begin to plan for the transfer of adult inpatient psychiatric services to the VA site, and

2) That the VA adult psychiatric bed complement be increased by 30 beds to accommodate this transfer of volume.

The Project Review Committee of the Metropolitan Health Board rejected this recommendation.

D. The 120-Bed Nursing Home

The hospital replacement includes 120 nursing home beds. The cost of this part of the project has not been separated from the total project. The VAMC currently contracts with local community nursing homes to provide the necessary nursing home care and has 175 such beds under contract or reserved to the VA. Testimony duuring the review indicated that this has proven sufficient to meet the needs of the VA hospital.

The GAO model indicated a hospital need for 40 nursing home beds. The proposed 120 beds stems from the VACO's policy position of providing 20 percent of overall veteran need by providing 40 percent, or 8 percent overall, in Federal VA facilities; 40 percent, or 8 percent overall, in community nursing homes; and 20 percent, or 4 percent overall, in state nursing home beds.

The methodology used by VACO to determine the number of nursing home beds at a VAMC site is found in Senate Print 12, A Report on the Aging Veteran, prepared by the VA and submitted to the Senate on January 5, 1978.

Staff has applied the methodology (time does not permit discussion of it here, a handout illustrating it will be ready Monday morning) to the population figures in the VAMC A-95 application.

The results of applying the VA's methodology provide a range of nursing home bed need in the Medical District.

1985		1990	
Low	High	Low	High
253	313	297	395
Midpoint: 283		Midpoint: 346	

Applying the VA methodology to estimate the need for nursing home beds in the Minneapolis VAMC primary service area indicates the following need according to the VA methodology:

1985		1990	
Low	High	Low	High
190	235	223	297
Midpoint: 213		Midpoint: 260	

Staff has two problems with the nursing home aspects of the project.

First, staff had to use artificially high population figures. The VA method essentially applies ratios to population cohorts of 65-74, 75-84 and 85+. The figures used in this review for over 65 have come from Exhibit 2-4 of the VAMC's A-95 application. These were the figures used by the VA in calculating beds needed under the GAO hospital bed model. The population over 65 in that exhibit were not broken down to 65-74, 75-84, and 85+. However, Exhibit 2-9 of the application does break the 65+ population down. The problem is the total population 65+ in the two exhibits do not equal one another and they should. Staff used the data from Exhibit 2-9 of the application to derive the nursing home bed need from the VA's model. Since that population data is artifically high the number of beds estimated to be needed will be high.

Secondly, the VA methodology is based on use rates from national Nursing Home Surveys performed in 1973-74, which do not provide for local variations.

The criterion used by the VAMC for patient placement is 3 to 3.5 nursing hours per patient per day. The average for the Metropolitan Area skilled nursing home patient for reimbursement purposes is 2.9 hours.

The goal used by the Health Board in the analysis of need for nusing home beds is 10 nursing home beds per 1,000 population. The VA model of providing 20 percent of overall veteran need translates to 7 beds per 1,000, which is well under the Health Board goal.

Staff sees two issues with the proposed unit. First is the lack of an outline of an overall plan to participate with all concerned parties in meeting nursing home bed needs. Second, the construction of the unit will have a significant impact on the community's supply of nursing home beds. The 175 beds now contracted from the local community by the VA will, in effect, be added back to the marketplace.

Staff concurs with the need for nursing home beds at the VAMC. They are needed for the continuum of care concept and to make more efficient and appropriate use of acute hospital beds.

The question of size remains as does the policy issue of the VA proceeding to institute a policy for the provision of nursing home resources without interfacing with local community groups. Although the 7 beds per 1,000 population ratio of the VA is below the 10 beds per 1,000 goal of the Metropolitan Health Board, it still represents a potential duplication of resources.

Sixty-five percent of nursing home patient costs are paid through the Medicaid program. Underutilization of nursing home facilities increases those costs.

The VA should participate with the respective HSAs in planning for construction of resources in this area.

This participation should commence immediately by the VA. It should inform the appropriate HSAs of the short-term and long-term plans, whether construction or contractual, for areas under HSA jurisdiction. The VA should work with the HSA and the local nursing home providers to determine the overall needs of the area--not just the needs of the VA and its system.

Until a more comprehensive plan can be agreed to by the VA system and local nursing home providers the VA should be conservative with respect to the number of nursing home beds it constructs. The Metropolitan Area currently has an oversupply of beds as indicated by occupancy figures. Occupancy overall in 1976 was 90.1 percent.

Staff concludes that it is appropriate for the VAMC to provide nursing home beds but until it works out an overall comprehensive plan with local providers the number of beds to be constructed should be limited to the 40 called for in the GAO model.

E. Discussion of Alternatives

1. Modernization versus Replacement

Testimony received during the course of the review indicated that replacement of the facility was not the original solution contemplated by the VA. Modernization studies for the main hospital building were undertaken but the cost of correcting the physical plant problems were said to be almost as expensive as the estimated replacement cost. Thus the decision was made to replace the entire facility.

2. A Voucher System

A number of critics of the VA system have said that hospital and medical care for veterans does not require a separate hospital or health system. Such criticism maintains that the debt owed by the nation to its veterans could be met by creating a funding mechanism or vehicle which allows a veteran the choice of his/her physician and/or hospital and pays the costs just as they are paid by the present system.

Staff is unaware of where or when the voucher system idea first was conceived. However, as recently as late 1979 the Maryland Hospital Association surfaced the idea as an alternative to construction of a new $100 million VA hospital in Baltimore. That Hospital Association said the voucher system would defer "colossal construction expenditures" while delivering quality care.

The main problem staff sees with this concept is the number of veterans who actually receive care under the VA system. Earlier sections of this report provided strong support for the position that only 20 percent of the veteran population receives their hospital needs in the VA system. The voucher idea would have to include all veterans or restructure the eligibility provisions that now exist—for example, including only service-connected disabilities or excluding those 65 and over. While the concept of a voucher system is appealing, it is not without its own fiscal, administrative and orgaizational problems. However, with the increasing number of women in the armed services there will be an increased number of women veterans. Inasmuch as the VA hospital is oriented to the male patient, the increased number of women veterans provides an opportunity for a pilot program the VACO could develop to test the voucher system or aspects of it for obstetrical and gynecological services.

3. Bed Size

The construction of a 725-bed hospital and 120-bed nursing home will result in physical facilities that are adequate for at least 40 years, if not longer. The appropriate bed size is, therefore, a serious matter. The size of the Minneapolis VAMC should be restudied. At the minimum this should include recalculation of the VA/GAO model using more recent data.

Because of the burden on the nation's resources due to hospital costs and the present underutilization of hospitals in this area, staff feels that the size of the hospital should take into account several factors:

a. Only 30 percent of the proposed acute beds are for veterans with service-connected disabilities.
b. Fifty percent to 60 percent of the proposed acute beds are for veterans who are 65 and over.
c. Veterans over 65 are eligible for Medicare coverage and the construction of a $264.6 million hospital represents a massive potential duplication of hospital resources.
d. The projected need of 725 beds is heavily dependent on an assumption that those veterans who will reach the age of 65 in the decade of the 1980s will use the Minneapolis VAMC at the same rate as those now over 65. If more of them (ratio-wise) prefer the non-VA system, the construction of this 725-bed hospital will be oversized. There is some indirect evidence to support the premise that those reaching 65 years of age in the 1980s will prefer the community hospital system more than those 65 and over who now use the VA system.

What would be the effect on acute beds needed if some of the above issues become reality in the next five to fifteen years?

	Acute Beds Needed
VA/GAO Model (i.e. current practice or no restriction on beneficiary use)	619
Service Connected Disabilities (either S.C. or Non S.C. Illness)	186
Service Connected Illness Only	50
Voucher System	0
Under 65 Only	305
1979 Admission Rate	463
1978 Admission Rate	481
1977 Admission Rate	499

One function of a planning agency is to look at all the data and ascertain the trends that affect the need for expensive resources regardless of the popularity or unpopularity of that analysis. The one factor that arises throughout the analysis of this project is the substantial role of the 65-plus age group on the estimated need for resources.

Given the economic burden of hospital costs on the nation, the need to serve the veteran, the need to serve the elderly and the underutilization of community hospital resources, staff feels that data in Table XXXI which indicates an acute bed need of 493 in 1985 is the most supportable figure for acute beds. To that figure, the following should be added:

- 30-bed chemical dependency unit
- 10-bed GRECC unit
- 10-bed hemodialysis
- 6-bed long-term care neurology
- 30-bed non-acute Intermediate Care
- 30-bed non-acute Rehabilitation

609 acute and non-acute hospital beds

The question of the nursing home bed unit remains. At the minimum, staff recommends that only 40 beds be constructed pursuant to the GAO model.

4. Professional Standards Review

The National Academy of Sciences Report offered many recommendations to Congress that would have affected the VA health care system. One of its recommendations follows:

> "Rigorous procedures for admissions and utilization review should be developed and implemented within the VA system."[1]

The VA response to the NAS recommendation concurred with it.[2] However, in concurring the VA took exception with the idea that the VA did not already have procedures for admissions and utilization review when, in fact, the VA had been operating for three fiscal years its Health Services Review Organization (HSRO). The HSRO program includes quality assessment and utilization review and consists of two parts. Part one is the Systematic External Review (SERP) Program in which each facility undergoes a biennial survey which examines the hospital's allocation and utilization of resources as they affect the quality of care. Part two is the Systematic Internal Review (SIR) program in each facility which reviews aspects of hospital activities affecting quality of care.

The VA also noted, in its response, the need for length of stay standards to be used in utilization review and that such standards were in the process (1977) of development.

The NAS report also recommended that VA hospitals should be part of the utilization review, cost-control, and other quality assurance programs in force under PSRO and other legislation. The VA did not concur with this aspect of the NAS recommendation because it would involve a) non-VA control over VA facilities, b) because programs such as SERP and SIR were already in effect, and c) because locally determined criteria would be inapprorpiate and non-productive when imposed on hospitals that are part of a national health care system and which have a central management directed by Congressional mandates.

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[1] NAS Report, page 282.

[2] VA Response to NAS Report, page 69.

The NAS Report went on to say tht the "VA system could serve as a laboratory for developing, testing and implementing more effective methods of utilization review and quality assurance."[3] The VA Response did not comment directly on the above quote but did note that the "VA is the largest and probably the only health care delivery system in the U.S. that is capable of mounting such meaningful studies and carrying them to their successful concluson."[4] The "such... studies" referred to was the VA's Classification of Patient's Program then under development. This program was a system designed to classify patients by levels of care as they entered the VA health care system. Such levels of care include five levels of inpatient care, nursing home care, ambulatory and home health assistance.

While the VA perceives itself as unable to participate in PSRO activities it should not be barred from working with the PSRO for each to obtain the most useful results from each other's programs. Further, in anticipation of many more VA replacement projects the results of the Classification of Patients study should be required as part of any proposed replacement project as the results of that study affect the size and mix of VA proposed acute and non-acute hospital beds.

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[3] NAS Report, page 69.
[4] VA Response, page 73.

Section IV

FINDINGS

1. The Minneapolis VAMC is one of 172 VAMCs in the United States. It is a 736-bed hospital offering primary, secondary and tertiary care in medical, surgical and short-term psychiatry services to eligible veterans in its service area.

2. The Minneapolis VAMC was the first VA hospital to become affiliated with a medical school when the VA system began such affiliations in 1946.

3. The Minneapolis VAMC now ranks among the top of all VAMCs in educational affiliations and research activities which, along with its patient care role, make it one of the leading VA hospitals in the nation.

4. The 1979 Space and Functional Deficiency Identification (SFDI) system of the VACO has identified the physical plant of the Minneapolis VAMC as being in the 98th percentile of all VAMCs. This means that it was one of three VA hospitals with the most physical plant deficiencies of all VA hospitals in the nation.

5. The Minneapolis VAMC is proposing a complete replacement of its inpatient services and outpatient clinics at a total estimated construction cost of $221,400,000 with associated fixed and movable equipment costs estimated at $41,200,000.

6. The proposed replacement would result in a 725-bed hospital and 120-bed nursing home. The 725-bed hospital was determined, in part, by the VACO's use of a model developed by the General Accounting Office to determine appropriate hospital bed sizes in VA replacement projects.

7. There are three key variables in the GAO model that determine the ultimate bed size of a VA replacement project.

   A. Veteran population changes by age cohort: This project used projected population in the year 1985 which is one year prior to the scheduled completion date.

   B. Discharge rate (excluding one-day dialysis inpatient visits): This project used 1977 discharges at the Minneapolis VAMC. Discharges at this VAMC have continued to decrease in 1977, 1978 and 1979 even though the total veteran population in the PSA increased during those years. Use of 1978 or 1979 discharge rates would result in an estimate of fewer beds being needed.

   C. Average length of stay: This project used 1974 data in its length of stay comparisons. More recent data exists which shows a trend of continued decreases in lengths of stay. Decreases in legnth of stay for age 65 and over between 1976 and 1978 are significant and those 65 and over would require 50 to 60 percent of the acute care beds at the Minneapolis VAMC.

8. Trends in average length of stay in the U.S. for those over 65 have decreased between 1976 and 1978. It rose between 1977 and 1978 in North Central U.S. but continued to decrease in Minnesota, Wisconsin, Iowa, North and South Dakota. The Minneapolis VAMC receives 98-99 percent of its patients from those five states.

9. Veterans who have a service connected disability account for 30 percent of the acute beds in this project. Those veterans without any service connected disability account for 70 percent of the acute beds.

10. Nationwide, veterans with a service connected disability and veterans receiving a VA pension constitute about 11 percent of the veteran population and account for approximately 55 percent of the patient days generated at VA hospitals.

11. Data suggests one out of five veterans use the VA hospital system for their hospital needs.

12. The veteran population over 65 accounts for 50 to 60 percent of acute beds projected as needed by the VA/GAO model.

13. Federal Health Planning guidelines require a community hospital bed ratio of no more than four short-term beds per 1,000 population. This project, assuming 20 percent of the veteran population uses VA hospitals, results in a bed ratio of 6.2 short-term hospital beds in the year 1985.

14. Veterans over 65 years old will represent about 50 to 60 percent of all U.S. males over 65 in the late 1980s and early 1990s.

15. The University of Minnesota Hospitals and Clinics and the Minneapolis VAMC are both proposing replacement projects on similar time tables. Each anticipates construction to commence in 1981 and to be completed by 1986-87.

16. The VACO has instituted a regionalized system throughout the U.S. to assist it in attaining the mission and role of the VA health system.

17. One of the objectives of this regionalization is to improve utilization of available VA and community health resources and facilities.

18. The replacement projects of the University Hospitals and the Minneapolis VAMC will cost approximately one-half billion dollars.

19. This total replacement cost coupled with VA regionalization objectives on improving utilization of resources and facilities offers an excellent opportunity to share costly, specialized medical services between the two institutions.

20. The primary service area of the Minneapolis VAMC includes counties in Minnesota, Wisconsin and Iowa. This service area accounted for 87.6 percent of all patient days at this hospital in 1979.

21. The Minneapolis VAMC receives about 50 percent of its patients and its patient days from the Seven-County Metropolitan Area.

22. The veteran population in this primary service area is projected to decline from its peak of 547,117 in 1979 to 516,854 in 1990 and 501,653 in 1995.

23. Although the overall population is decreasing in the primary service area, the veteran population of 65 and over is projected to increase.

24. The effects of national policy changes on the need for acute hosital beds at this site are substantial as shown below:

Population Served	Acute Beds Needed
a. Current Practice or no restriction on beneficiary use	619 (per GAO model)
b. Service Connected Disabilities (either S.C. or non S.C. illnesses)	186
c. Service Connected Illness Only	50
d. Under 65 only	305
e. Admissions at:	
1) 1979 level	463
2) 1978 level	481
3) 1977 level	499

25. The Seven-County Metropolitan Area, from which the VA obtains 50 percent of its patient days, has 2,000 excess short-term, non-federal hospital beds.

26. The Minneapolis VAMC reduced the number of its operating beds from 862 to 738 in 1979. The number of outpatient visits at the hospital has been increasing since 1974. The number of visits by fiscal year are:

1974	155,989
1975	170,943
1976	191,462
1977	204,728
1978	203,021
1979	201,136
1980	210,000

27. Providers in the Seven-County Metropolitan Area have voluntarily participated with the Metropolitan Health Board since 1977 in a joint Long-Range Hospical Planning Process to reduce that excess capacity.

28. The Minneapolis VAMC was prohibited by VACO policy from participating in that process.

29. Veterans reaching the age of 65 will become eligible for two health care coverage systems: Medicare and the VA system.

30. The Minneapolis VAMC operates a hospital-based home care program that includes the following professional services: physicians, nurses, physical therapy, social workers, dietetics and home health aides. All eligible veterans may receive these services.

31. This dual coverage results in duplicate planning of hospital, nursing home and home care resources for up to one-fourth of the U.S. population over 65.

Section V

CONCLUSIONS

1. Health care expenditures in general, and hospital costs in particular, have been, continue to, and are projected to increase at rates which are imposing severe economic burdens on the nation and on individuals. Health care expenditures, which were 9.1 percent of the GNP in 1978, are projected to be 10.5 percent in 1985 and 11.5 percent in 1990. Hospital costs which accounted for 39.5 percent of all health care expenditures in 1978 are projected to consume 41.7 percent in 1985 and 44.1 percent in 1990.

2. Planning the estimated need for hospital and nursing home resources is heavily dependent on the population cohort 65 and over because this age cohort use hospitals and nursing homes at a much higher rate than any other age group. Population projections indicate that between 1985 and 1990, 55 percent of all U.S. males over 65 will be veterans. This will be approximately one-fourth of the population over 65. Since the enactment of Medicare most of these persons have dual coverge by the Medicare and Veterans Affairs programs. Failure to coordinate and integrate local community and VA planning efforts for the delivery of health services (including hospitals and nursing homes) to this age group requires additional attention so that a substantial duplication of scarce and expensive resources does not occur.

3. The public and private hospitals in the Seven-County Metropolitan Area and the Metropolitan Health Board began a voluntary process in 1977 that is expected to result in the reduction of 2,000 excess licensed acute hospital beds in the Minneapolis-St. Paul area by 1983. Each hospital, as part of this process, submitted its long-range hospital plan to the Metropolitan Health Board in December of 1978. Although the Minneapolis Veterans Administration Medical Center was preparing its own five-year plan for the VACO at that time, VACO policy prohibited participation of the local VAMC in that voluntary process.

4. Data from VA sources indicate that approximately 20 percent of the veteran population using hositals use the VA hospital system. The VA hospital system should plan the provision of its resources accordingly and also in accordance with the guidelines placed by the Federal government on the non-federal community hospitals.

5. The VA hospital in Minneapolis has played an important role in the local community, state, Upper Midwest and nation by virtue of its education, research and clinical role(s).

6. It is operating in a physical plant that is sorely inadequate and in need of replacement.

7. The construction of a new hospital to replace the existing facility is appropriate but the size of the replacement is a question deserving serious scrutiny because:

a. The GAO model used to determine the proposed size of the replacement project has two important assumptions: discharge rate and length of stay. The discharge rate at the Minneapolis VAMC has continued to decline since 1977—the base year used in the original calculation of 725 beds. Length of stay data indicate a decreasing trend between 1974 and 1978. The proposed 725-bed hospital was based on 1974 length of stay data.

b. The model used by the VACO in determining bed size is particularly sensitive to the length of stay of those 65 and over because of the rapid increase in the number of such veterans. The length of stay for this age cohort has continued to decrease between 1974 through 1978. Its decrease is signficiant in these five states (Minnesota, Wisconsin, Iowa, North and South Dakota) which comprise 98-99 percent of the Minneapolis VAMC patient days.

c. Another assumption in the model is that those veterans reaching 65 in the decade of the 1980s will use VA hospitals at the same rate as those veterans who reached 65 in the 1970s. There is some evidence to suggest this may not be true.

8. The concurrent time table for replacement of both the University Hospitals and the Minneapolis VAMC offers an excellent opportunity for sharing specialized and costly services between these two institutions.

9. Existing policy decisions and legislative authority should not be a barrier to examining the ramifications of those policies and statutes.

10. Whatever bed size is ultimately decided, the construction cost should not exceed the estimated $221,400,000.

11. Review of replacement projects should include projected operating costs upon completion of the project and the basis for any estimated saving in operational costs because of the replacement.

Section VI

RECOMMENDATIONS

1. The total hospital bed size (acute and non-acute) should not exceed that number of beds which supportable data suggests is needed. Analysis of the data provided in this report suggets that a maximum of 609 hospital inpatient beds (acute and non-acute) be constructed at the same site to replace the present Minneapolis VAMC inpatient hospital facility.

2. Construction costs (excluding movable equipment costs) of the VA hospital replacement project should not exceed $221,400,000.

3. The VA should plan to consolidate its programs in Radiation Therapy and Renal Transplantation at the University.

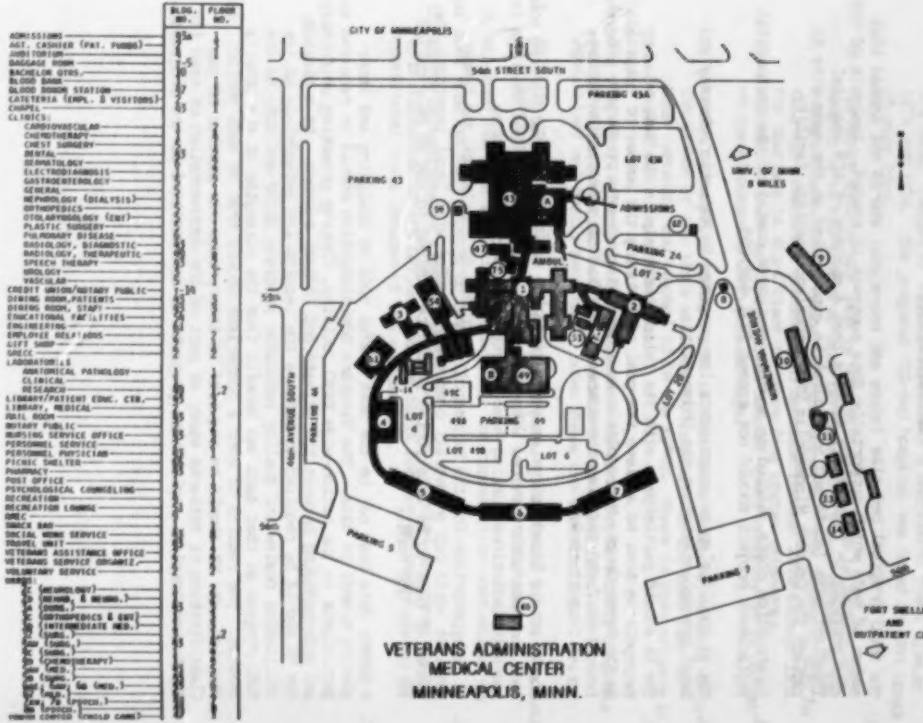
4. The VA should participate with its fellow hospitals in the Seven-County Metropolitan Area to achieve the goal of reducing the number of hospitals in the Seven-County Metropolitan Area operating open-heart surgery programs from 13 to 7 and reducing the number of cardiac catheterization laboratories from 13 to 9.

5. The VA should immediately integrate its plans for provision of nursing home beds and home care services with state and local providers and the HSAs in whose jurisdictions nursing home construction would take place.

6. It is appropriate for the Minneapolis VAMC to provide nursing home beds but until it works out an overall comprehensive plan with local providers the number of beds to be constructed should be limited to the 40 beds called for in the GAO model.

7. A common data base can be the most useful tool in analyzing and interpreting trends in data. The Veterans Administration should be required to participate in the nation-wide PSRO activity, thereby promoting uniformity and understanding between the private and federal sectors. At a minimum, the VA should be required to compare the results and methodology of its utilization review and quality assurance programs (SERP and SIR) to the PSRO program so that each can benefit from the strengths of the other's program. The results of such a comparison should then be made public. In addition, the VA should be required to incorporate the results of its Classification of Patients study as part of the documentation of need for any future hospital replacement projects to be submitted to the Congress.

EXHIBIT I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FLOOR NO.
ADMISSIONS
AGT. CASHIER (PAT. FUNDS)
AUDITORIUM
BAGGAGE ROOM
BACHELOR QTRS.
BLOOD BANK
BLOOD DONOR STATION
CAFETERIA (EMPL. & VISITORS)
CHAPEL
CLINICS:
CARDIOVASCULAR
CHEMOTHERAPY
CHEST SURGERY
DENTAL
DERMATOLOGY
ELECTRODIAGNOSIS
GASTROENTEROLOGY
GENERAL
NEPHROLOGY (DIALYSIS)
ORTHOPEDICS
OTOLARYNGOLOGY (ENT)
PLASTIC SURGERY
PULMONARY DISEASE
RADIOLOGY, DIAGNOSTIC
RADIOLOGY, THERAPEUTIC
SPEECH THERAPY
UROLOGY
VASCULAR
CREDIT UNION/NOTARY PUBLIC
DINING ROOM, PATIENTS
DINING ROOM, STAFF
EDUCATIONAL FACILITIES
ENGINEERING
EMPLOYEE RELATIONS
GIFT SHOP
GRECC
LABORATORIES
ANATOMICAL PATHOLOGY
CLINICAL
RESEARCH
LIBRARY/PATIENT EDUC. CTR.
LIBRARY, MEDICAL
MAIL ROOM
NOTARY PUBLIC
NURSING SERVICE OFFICE
PERSONNEL SERVICE
PERSONNEL PHYSICIAN
PICNIC SHELTER
PHARMACY
POST OFFICE
PSYCHOLOGICAL COUNSELING
RECREATION
RECREATION LOUNGE
SNACK BAR
SOCIAL WORK SERVICE
TRAVEL UNIT
VETERANS ASSISTANCE OFFICE
VETERANS SERVICE ORGANIZ.
VOLUNTARY SERVICE
WARDS:
(NEUROLOGY)
(REHAB. & NEURO.)
(SURG.)
(ORTHOPEDICS & ENT)
(INTERMEDIATE MED.)
(SURG.)
(SURG.)
(SURG.)
(CHEMOTHERAPY)
(MED.)
(SURG.)
(MED.)
(MED.)
(PSYCH.)
(PSYCH.)
(CHILD CARE)
CITY OF MINNEAPOLIS
54th STREET SOUTH
PARKING 43A
LOT 43B
UNIV. OF MINN. 8 MILES
ADMISSIONS
PARKING 43
PARKING 24
LOT 2
AMBUL
LOT 2B
MINNEHAHA AVENUE
48th AVENUE SOUTH
55th
56th
PARKING 4A
49C
LOT 4
49A PARKING 49
LOT 49B
LOT 6
PARKING 5
PARKING 7
FORT SNELLING AND OUTPATIENT CLINIC

VETERANS ADMINISTRATION
MEDICAL CENTER
MINNEAPOLIS, MINN.

EXHIBIT II

Metropolitan Council
OF THE TWIN CITIES AREA

300 Metro Square Building, 7th Street and Robert Street, Saint Paul, Minnesota 55101 Area 612, 291-6359

January 31, 1978

Mr. Daniel E. Cooney
Hospital Director
Veterans Administration Hospital
54th Street and 48th Avenue South
Minneapolis, MN 55417

RE: Replacement of Boiler Plant
Metropolitan Council Referral File No. 4738

Dear Mr. Cooney:

At its meeting January 26, 1978, the Metropolitan Council considered the above project. This project was reviewed by the Council's Metropolitan Health Board. They voted to forward a favorable A-95 comment on the boiler plant replacement with the provision that this recommendation does not imply a position on the part of the Health Board with respect to any future expansion/replacement projects at this site. The Council voted to concur with recommendation from the Health Board.

Sincerely,

METROPOLITAN COUNCIL

John Boland

John Boland
Chairman

JB:pt
cc: John D. Chase, M.D., Chief Medical Director
David Niklaus, Coordinator, City of Minneapolis
Ollie Byrum, Director of Planning, City of Minneapolis
John Hurley, Metropolitan Council staff

An Agency Created to Coordinate the Planning and Development of the Twin Cities Metropolitan Area Comprising:
Anoka County ○ Carver County ○ Dakota County ○ Hennepin County ○ Ramsey County ○ Scott County ○ Washington County

EXHIBIT III

SEQUENCE OF OPERATIONS IN DETERMINATION OF HOSPITAL SIZE

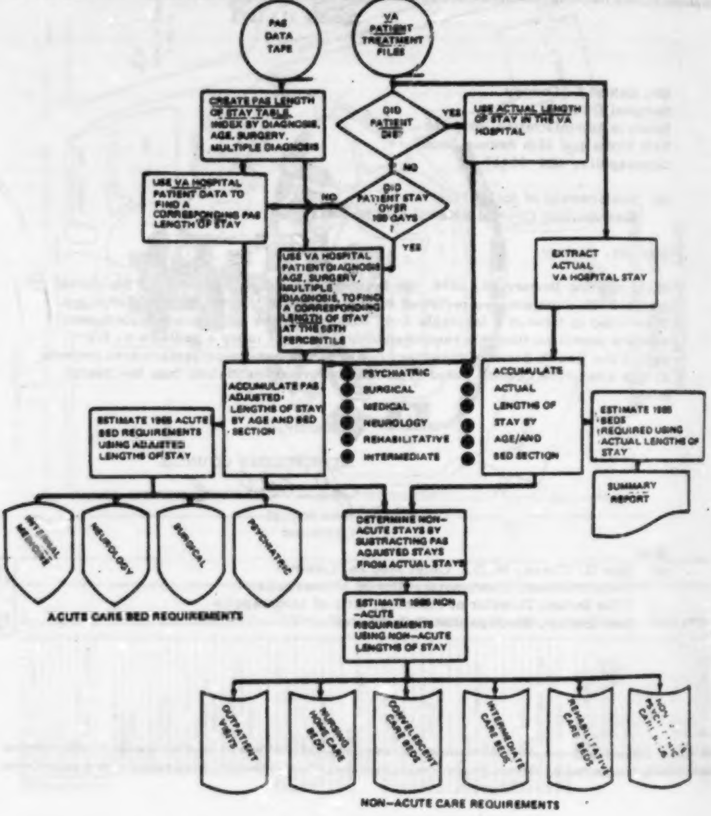
PAS DATA TAPE
VA PATIENT TREATMENT FILES
CREATE PAS LENGTH OF STAY TABLE, INDEX BY DIAGNOSIS, AGE, SURGERY, MULTIPLE DIAGNOSIS
DID PATIENT DIE?
YES
USE ACTUAL LENGTH OF STAY IN THE VA HOSPITAL
NO
DID PATIENT STAY OVER 100 DAYS ?
NO
USE VA HOSPITAL PATIENT DATA TO FIND A CORRESPONDING PAS LENGTH OF STAY
YES
USE VA HOSPITAL PATIENT DIAGNOSIS AGE, SURGERY, MULTIPLE DIAGNOSIS, TO FIND A CORRESPONDING LENGTH OF STAY AT THE 95TH PERCENTILE
EXTRACT ACTUAL VA HOSPITAL STAY
ACCUMULATE PAS ADJUSTED LENGTHS OF STAY BY AGE AND BED SECTION
PSYCHIATRIC
SURGICAL
MEDICAL
NEUROLOGY
REHABILITATIVE
INTERMEDIATE
ACCUMULATE ACTUAL LENGTHS OF STAY BY AGE/AND BED SECTION
ESTIMATE 1985 BEDS REQUIRED USING ACTUAL LENGTHS OF STAY
SUMMARY REPORT
ESTIMATE 1985 ACUTE BED REQUIREMENTS USING ADJUSTED LENGTHS OF STAY
INTERNAL MEDICINE
NEUROLOGY
SURGICAL
PSYCHIATRIC
ACUTE CARE BED REQUIREMENTS
DETERMINE NON-ACUTE STAYS BY SUBTRACTING PAS ADJUSTED STAYS FROM ACTUAL STAYS
ESTIMATE 1985 NON-ACUTE REQUIREMENTS USING NON-ACUTE LENGTHS OF STAY
OUTPATIENT VISITS
NURSING HOME CARE BEDS
CONVALESCENT CARE BEDS
INTERMEDIATE CARE BEDS
REHABILITATIVE CARE BEDS
NON- PSYCHIATRIC CARE
NON-ACUTE CARE REQUIREMENTS

Exhibit IV
List of Speakers at the April 30, 1980 Public Hearing

*1. Daniel Cooney, Director, Minneapolis VAMC

2. Robert Christenson, President, West Metro Hospital Trustee Council

3. Ted Kolderie, Executive Director, Citizens League

4. Harry Lemieux, United Veterans Legislative Committee of Minnesota

5. Mike Ohnstad, Director of Rehabilitation, American Legion, State of Minnesota.

6. Lawrence Poston, M.D., Vice-Speaker, Minnesota Medical Association House of Delegates.

7. Stuart Hanson, M.D., Chairman, Physicians Metro Health Force

8. John O'Neil, Jr., Adjutant Quartermaster, Department of Minnesota, VFW

9. Lyle Pearson, Past National Commander, DAV

10. Joseph O'Neil, East Metro Hospital Trustees

11. Donald Miller, Commissioner, Veterans Affairs, State of Minnesota

12. Richard Frey, M.D., Chairman, Minnesota Coalition on Health Care Costs

13. John Tonneson, Commander, Chapter 1, DAV

14. Lynn Kiehne, Council of Community Hospitals

15. Robert Connor, Vietnam Veterans

16. William Meyer, Dakota County Veterans Services Director

*17. Hazel Hill Turk, World War II Disabled Veteran

*18. Robert Callahan, American Legion

19. Donald Kvidt, Chairman, Ramsey County United Veterans Council

20. Marlene Nelson, VAMC Volunteer

*21. Lester Leider, Hospital Administrator

*22. Wendell Peterson, Disabled Veteran

**23. James Dustrade

*Did not leave copy of remarks.
**Left copy of remarks but did not speak.

Exhibit V

Newspaper Editorials

Minneapolis Tribune
Established 1867
Charles W. Bailey Editor
Wallace Allen Associate Editor
Frank Wright Managing Editor
Leonard Inskip Editorial Editor
Donald R. Dwight Publisher
20A
Sunday, February 17, 1980

Separate new VA hospital is wasteful

The American public is growing increasingly disenchanted with the performance of the federal government, according to consistent findings of opinion polls. Much of the blame goes to unresponsive programs, to remote, single-purpose bureaucracies and to Congress's habit of assuming that federal largess automatically solves problems.

Minnesota is about to witness a classic example of what bothers people. An oversized and expensive new federal installation apparently will be designed with little attention to community planning or to avoiding a costly duplication of facilities. Once built, it will be unnecessarily costly to operate.

The project is a $220-million Veterans Administration Hospital in the Twin Cities. Although President Carter's 1981 budget contains $15 million to plan the hospital, the administration apparently has already made two vital decisions: The hospital will be a separate, independent unit, and it will be located at Fort Snelling, site of the present VA hospital.

Never mind that the University of Minnesota also proposes to replace its equally old hospital at a cost of at least $220 million; that planning and building part or all of the new VA hospital jointly with the university would offer important savings; that joint operation was proposed in 1970 by the university medical school; that both hospitals engage in teaching and research, as well as patient-care. And never mind that most VA hospital doctors have joint appointments at the university.

The project is not subject to approval by the Metropolitan Health Board or Metropolitan Council, even though a federal cost-containment law requires that they approve all other metropolitan-area hospital construction. Apparently Congress and the Carter administration find that containing community hospital costs is desirable, but containing federal hospital costs is not.

The Carter proposal is for 845 beds, 100 more than the VA hospital now operates, even though the hospital now is only 78-percent occupied. Further, under federal law, the Metropolitan Health Board and the other Twin Cities-area hospitals, whose occupancy rates are just below 75 percent, are working to close about 1,000 excess beds — and those hospitals next must trim duplicate services and even more beds.

Veterans have a legal right to free medical care, and the country long ago chose — for better or worse — to provide this care in a separate hospital system. The old Fort Snelling facilities are outmoded; a 1978 study found only two other veterans' hospitals in worse physical shape.

But none of that means a veterans hospital should or must be planned, built and operated independently. Nor does it mean a new veterans hospital should have 200 or 300 beds more than needed. And it does not mean that equal, or better, care could not be provided veterans if a new VA hospital shared facilities with a new university hospital. Just one example: If all surgical units from both hospitals were combined at the university, the duplication of about 200 beds and other expensive equipment and services would be avoided.

Building two large and entirely separate hospitals in the Twin Cities at a cost of nearly a half-billion dollars is plainly not justified — especially when health-care costs are soaring, and the president cannot deliver on his pledge to balance the federal budget. But the capital costs, though large, should be less alarming to taxpayers than the prospects for ongoing operating costs; hospital operating budgets over two years usually equal the original capital costs.

Vice-President Mondale apparently was instrumental in getting the Carter administration to approve a new Fort Snelling hospital. And Rep. Martin Sabo, whose district includes the Fort Snelling area, sits on the House appropriations subcommittee that will handle the hospital. Sabo, to his credit, suggests that the two projects should be planned cooperatively. But suggestion alone won't get the job done. Mondale and Sabo should team up in the public interest and support a joint-planning and facility-sharing *requirement* in the appropriations bill.

Multimillion-dollar proposal for hospital should face review

VA's plan bypasses public scrutiny

By RICHARD J. FREY, M.D.
Of The Star's Board of Contributors

In this era of public accountability and responsibility in government, the 240.6 million proposal to replace the Veterans Administration Hospital at Fort Snelling must stand out as the hallmark of hypocrisy.

This metropolitan area has demonstrated the resolve to address responsibly the problem of escalating health care costs. The Metropolitan Health Board has been charged with the responsibility of recommending approval or denial for all extensions of health care facilities after careful review of community needs and institutional capacities. Individual proposals have been subordinated to what is deemed to be in the common interest of the community.

All private and non-federal public hospitals are subject, by law, to abide by the decision resulting from this review. This is designated as Certificate of Need legislation with a final decision made by the Commissioner of Health.

Far more important in this community is the coalition of private and public forces giving a refreshing thrust to the entire health care cost-containment effort. Alternative forms of health care are being promoted so customers have more freedom in choosing a plan that suits them. Competition to encourage greater efficiency, more rigid accountability and technological innovations are being introduced.

Many dedicated consumers and providers are giving selflessly of their time and talents to this effort. How must they feel as they look at the VA proposal and the Veterans Administration's refusal to submit to the same community review before launching a multimillion-dollar project that will have a major impact on health care in this community?

The question now is not the need, or lack thereof, to replace obsolete facilities at Fort Snelling. At issue is the proposal to spend these dollars for health care facilities in this community without submitting to the same public review to which all other health facilities are subjected. This double standard by a government agency destroys the credibility of our federal government's expressed interest in responsibly controlling health care costs. It frustrates the voluntary effort to promote cost cutting when the federal arm is willing to spend lavishly without public scrutiny. If the proposal cannot stand on its own merit, the facilities should not be built. If it meets local needs, the federal government should welcome public review and acceptance.

We can presume that the many members of the various veterans' organizations, as taxpayers and responsible citizens, share a concern for accountability in public spending. I suspect most would welcome a full review of this proposal before we commit this large expenditure to health care facilities, which we may or may not need at this time, not to mention the even greater amount that will be needed to meet operational costs.

Call it what you will—double standard, lack of accountability, denial of accepted process—it is hypocrisy in every sense and destructive to the positive forces in this enlightened community.

FREY is an internist who is chairman of the board of the Minnesota Medical Association and chairman of the association's cost commission.

VA hospitals are for veterans, not local community

To the Editor: Dr. Richard Frey's negative article (April 15) concerning the VA's proposal to replace antiquated hospital facilities sounded very self-serving. Dr. Frey, as chairman of the Medical Association cost commission, is instinctively biased toward profit-based hospitals (as well as toward M.D.s) that would gain large financial benefits if the VA proposal were scrapped.

Dr. Frey's main rationale for opposing the VA hospital addition is the Metro Health Board's lack of jurisdiction over approval of expenditures. As was stated several times in the Frey article, approval should be required to see if "local needs" are met. How objective would the Metro Health Board be? The VA hospital encompasses more than the metro area; during my stay at the VA it was unusual to find anyone from the Twin Cities. I do not know the percentage of the almost 200 people who are dealt with each day in admission who are from the metro area, but while I was in the surgical ward, the majority of vets were not from Minnesota.

If Dr. Frey's intention is to combine the VA services with local facilities, where does the VA stand when a bed occupancy rate improves through increase in use of non-veteran patients?

Also, are the private hospitals equipped to handle veteran problems or those vets who are unable to afford the cost of diagnosing a health problem that may not be service-connected? I'm assuming the private hospitals would require substantial compensation from the feds if their services were used.

Are the private hospitals more efficient than the VA—with its mass of volunteers? The VA volunteers not only relieve some of the burden on the VA staff, but I feel are an intricate part of recovery. It is beneficial to know one's health is not always equated with money.

I realize I am also biased since I could not have afforded the diagnosis and removal of a brain tumor had it not been for the VA.

—Todd N. Sorlie
Crystal

On the contrary, VA hospital inviting review

To the Editor: On April 15 *The Star* published a column [by Dr. Richard Frey of *The Star's* Board of Contributors] titled "VA's plan bypasses public scrutiny." It is unfortunate that readers of *The Star* were provided with inaccurate information regarding community review of the Veterans Administration's proposed replacement hospital in south Minneapolis.

The author of the column alleged that the VA has refused to submit to a public review of the replacement facility. This is misleading and incorrectly implies that the VA has circumvented the community review process. The VA is taking every available opportunity to allow for community review of the proposed VA replacement hospital.

The Metropolitan Health Board has been given a tour of the existing VA facility, and Medical Center staff have been participating in weekly project review sessions with the board. These meetings will culminate in a public hearing on April 30. It is the VA's policy to cooperate fully with state and local governments and planning agencies in the evaluation, review and coordination of major construction projects.

In addition to local review, a staff inquiry to review the proposal was conducted by the U.S. Senate Veterans Affairs Committee on April 8 in Washington, D.C. Representatives from the Metropolitan Health Board, the Council of Community Hospitals, the West Metro Hospital Trustees Council and the author's own Minnesota Medical Association were all invited participants in the session.

The column also surfaced the issue of the need to replace the facilities at Fort Snelling. The Minneapolis VA Medical Center has been rated among the three most functionally and spatially deficient in the VA health care system, which includes 172 medical centers and 219 outpatient clinics. Approximately 40 percent of the Minneapolis VA medical Center's operating beds are located in buildings of 1927 vintage.

The intent of replacing the VA Medical Center is to provide a safe and functionally sound facility to meet the needs of veterans in the Upper Midwest. Also, it should be noted that the health service area for most Twin Cities hospitals consists of seven counties, whereas the VA Medical Center's primary service area consists of 72 counties. More than 47 percent of veterans treated at the Minneapolis VA are from outside the seven-county metropolitan area.

In conclusion, the VA is committed to a policy of cooperation with local government and planning agencies and in providing the highest quality medical care to our veteran population.

—Daniel E. Cooney, Director,
VA Medical Center
Minneapolis

Exhibit VI

Ver Batim Comments of Speakers

Testimony of

Robert Christenson

TESTIMONY TO THE METROPOLITAN HEALTH BOARD
PUBLIC HEARING OF THE A-95 REVIEW ON THE VETERANS' HOSPITAL
Wednesday, April 30, 1980

I am Robert Christenson, President of the West Metro Hospital Trustee Council, a voluntary group comprised of the leaders of 16 community hospitals and two hospital corporations in the greater Minneapolis area.

For the past two and one half years, the West Trustees have taken an active role in the development of a community health plan in the metropolitan area. Our efforts surfaced most visibly with the publication of our report, Recommended Changes in the West Metropolitan Health Care System: The Voluntary Sector's Approach, in October 1978, which presented to the Health Board our position on the capacity of hospitals, our recommendations on bed reduction and specialty service consolidation and our recommendations on eight additional health care issues facing the community.

We have also worked with the Health Board in designing the procedures for evaluation of our planning process and the proposed changes in the hospital system over the coming years. We believe that the evaluation of the impacts of bed reduction and specialty service consocidation on cost, quality, and access are critical to responsible community planning.

We are strongly committed to the community planning process that has been developing in our area over the past years. We believe strongly that voluntary solutions to complex social and economic problems are normally preferable to and more effective than government imposed solutions. Therefore, we have regularly supported the participation of all key health organizations and constituencies in the planning process.

We state with deep concern our strong opposition to the development of health care facilities independently of the local planning process, whether they are Federal facilities or private facilities.

As the voluntary leaders of our individual hospitals, we have committed to making sacrifices for the good of the total community, rather than limiting our concern and attention to the interests and goals of our own institutions exclusively.

It is, in our opinion, inappropriate for the Federal government which developed the legislation to put a health planning process in place in the community to function outside of that legislative intent. The spirit of the law is jeopardized if a new Veterans hospital system for the nation is planned without incorporating that planning into the local process underway.

We are not opposed to upgrading and improving the Veterans Hospital in this area. We recognize that the current operation needs renewal. We strongly support the right of Veterans to have access to quality health care facilities. We do believe, however, that the changes being proposed present an opportunity for the Veterans system to merge their project planning into the community health planning process that is in process for the wider metropolitan area.

Mr. Cooney has stated that "it is the VA's policy to cooperate fully with state and local governments and planning agencies in the evaluation, review and coordination of major construction projects."

We would suggest that cooperation must extend beyond agreement to submit to review. A superficial or cursory review and comment without commitment by the VA Hospital to take into account and conform to the recommendations is not satisfactory.

We trust that Mr. Cooney means that the VA Hospital will undergo the same planning process as other health care facilities in this community to ascertain how the new VA Hospital conforms to community standards and expectations.

We recognize that the Veterans' Hospital serves people from outside the area. However, over 50% of its patients, according to Mr. Cooney, are from our area. This represents a substantial capital investment to serve people from within the area. Such an investment should not be made without considering how the results will impact the total community. The question is not _if_ the planning should proceed for the Veterans' Hospital, but rather, how it should proceed.

As the voluntary leaders of the community hospitals in the West Metro area, we want to emphasize that this is a unique opportunity for the Federal government to provide support for the local planning process and health delivery system in our community, as they begin this new major project in this area. The project should not proceed to the detriment of the wider community.

The goal must be to assure that the health care needs of the veterans are met within their facility, while at the same time enhancing the overall goals of the health delivery system as a whole, (recognizing that many veterans choose to use that system and not the Veterans' system.)

We acknowledge with pride the contribution being made by the Veterans' Hospital in health care delivery and professional education in this community. It is important that that role be preserved and enhanced through the new development.

We are convinced as hospital trustees that the proposed Veterans' Hospital system can be responsive to veterans' needs, and also to local community needs, and that these two goals need not be in conflict. We are further convinced that responsibility to the American taxpaying public requires the expenditure of any Federal funds to take into account all alternative ways in which the goals can be realized, in order to identify the most cost effective and efficient approach. This can only be accomplished if the Veterans' Hospital is planned and developed within the context of the wider community system. To ignore that system, or to proceed in isolation from that system, will most surely dilute the effectiveness of the dollars expended.

We are hopeful that the coming months will bring the community hospitals and the Veterans' Hospital closer together as this project moves forward. Our goal as Trustees is to support the enhancement of health care for Veterans, while enhancing health care for the community as a whole.

Robert E. Christenson
President
West Metro Hospital Trustee Council

Testimony of

Ted Kolderie

CITIZENS LEAGUE
530 Syndicate Building
Minneapolis, MN 55402

April 30, 1980

STATEMENT ON VETERANS ADMINISTRATION HOSPITAL

1. Madam Chairperson, Members of the Board, thank you for giving us an opportunity to appear.

2. In trying to deal with the issues raised by the proposal for a reconstruction of the Veterans Administration hospital in Minneapolis, we have found it helpful to go back and try to get in front of us clearly just what the VA hospital system is. In this respect, of course, one of the most useful documents is the report on the Veterans Administration hospital system by the panel of the National Academy of Sciences in 1977: a critical report in some respects, but helpful for its outside perspectives, on a subject on which outside perspectives are seldom offered.

   There was a good summary of its conclusions, recommendations and essential thrust carried in the New England Journal of Medicine, March 16, 1978, written by the chairman of the panel, Dr. Sol Farber. Let me quote a bit from his article in the Journal:

   "The Veterans Administration is the largest single provider of health care in the United States, with 171 hospitals, 85 nursing homes, 17 domiciliaries. The total bed capacity of the VA hospital system is over 111,000.

   "The VA budget for health care in 1977 was about $5 billion. . . it is providing care for about 3 million out of about 30 million living veterans, mainly in its own facilities. A large proportion have low incomes, are single, widowers, or divorced. Only 17% of the users under age 65 have health insurance. Almost half the in-patients are receiving long-term, domiciliary, or psychiatric care. The VA serves a male population with defined social and economic, but not distinct medical, characteristics.

   "The VA health care system was established after World War I to provide care for veterans with service-connected disabilities. The lack of community facilities in the 1920s encouraged Congress to permit the VA to provide care for needy veterans with non-service-connected disabilities. Less than 30% of the 3 million veterans presently served by the VA have service-connected disabilities. Current eligibility laws make any veterans who states that he cannot afford medical care eligible for care in the VA system.

   "In analyzing this large acute-care segment, where the VA concentrates its activities and resources, the committee found several very important problems. These do not stem from mis-management, but have deep historical roots. Geographical distribution is uneven; rural areas of the country have little if any VA care. Almost everywhere in the system there is a marked imbalance between in-patient and out-patient facilities. In-patient facilities are inappropriately used. There are twice the number of medical and surgical beds necessary. This situation is not true in every hospital, but it is systemwide. The average length of stay in medical-surgical beds in VA hospitals is much longer than that of comparable patients in the community hospitals. Special facilities, such as cardiac catheterization or renal dialysis are under-used. . . "

The report of the Metropolitan Health Board makes many of these same comments, though not all, with respect to the Minneapolis VA hospital specifically. Especially with respect to the average length of stay, which appears to be about twice the average in the general community hospitals.

3. The next thing to understand is the very large capital plant expansion proposed by the VA, seen in its nationwide dimensions. This was well summarized in an article in the magazine Modern Healthcare for April, 1980. Let me quote just a bit from that:

> "The largest multi-hospital system under single management, the VA medical system, will undergo a billion dollar facelift in the next few years. The VA will replace eight hospitals, and construct one new institution.
>
> "The VA must build in the 1980s if it expects to meet expected service demands of World War II veterans, most of whom will be age 65 in this decade. Long term and geriatric care needs are expected to soar. Service-disabled veterans, however, will continue to receive care first.
>
> "Seven VA medical centers are currently being replaced, and an 8th replacement is scheduled for Minneapolis, but it has not yet received complete funding. As a provider for more than one million in-patients annually, the VA is experiencing inflation on a grand scale. Three of its current replacement projects -- Baltimore, Seattle, and Little Rock, Arkansas -- will cost $57.7 million more than was budgeted, as a result of rising construction costs since fiscal 1978.
>
> "Replacement hospitals are also being built at Richmond, Virginia, Bay Pines, Florida, Martinsburg, West Virginia, and Portland, Oregon. The total estimated cost for the seven projects if $795 million.
>
> "The most costly projects is an 845-bed medical center in Minneapolis . . . all but one building in the Minneapolis VA medical center will be replaced . . . it now houses the largest educational and research programs in the VA system.
>
> "Other notable projects include close to $61 million for nursing home construction and $10 million more for domiciliaries. More than $52 million is sought for out-patient improvements. More than $92 million will be spent on clinical improvements . . . "

4. Before turning to the issues involved in the local hospital, it might be useful to make a comment or two about the larger scope of this proposal. That is, in the form of a couple of questions.

   First, why is the VA concentrating so much of its expenditure on hospital facilities, when a number of the facts about their system, and its population, would suggest that what is really required is housing, or long-term domiciliary and nursing care, or social service programs?

   Second, why -- if we are to believe the NAS panel that the VA facilities are mal-distributed around the country, in relation to the veterans population --

is the VA building so large a hospital in the Twin Cities area (surely one of the metropolitan area's best supplied with hospital facilities), rather than in some other part of the country not so well served as this one, with both short-term and long-term health care facilities?

5. Early in March of this year the president of the Citizens League, Allan Boyce, at the direction of the Board, wrote letters to a number of federal officials, with respect to the proposal for the replacement hospital at Fort Snelling. Here is what he said:

> "A real, and difficult, issue is emerging here in the Twin Cities area . . . with respect to the attitude of the federal government toward the size, and cost, of the hospital system. I wanted to be sure you are aware of the growing concern here . . . and the confusion . . . about whether the federal government really wants this community to put some restraints on the size and growth of its hospital system, or not.
>
> For something like twenty years, now, we have been pressed by the federal agencies (both those concerned with hospitals, and those concerned with expenditures) to do a better job of hospital planning: to cut out unneeded beds, and to make sure that expansion and new investment is reasonably related to needs.
>
> The Twin Cities area has been doing this . . . perhaps, as well as and as aggressively as any metropolitan area in the country. The health systems agency here is, I believe, well respected. Within the past year it has made some extremely difficult decisions, requiring a reduction in the hospital capital plant, and denying requests for new construction.
>
> And this effort extends into the private sector, as well. The Citizens League, as a private, non-profit non-partisan public-affairs organization, has been involved with hospitals in a substantial way, throughout its 28-year existence. At our urging, in 1970, Hennepin County government and Metropolitan Medical Center (a private hospital complex) did enter into new relationships for the planning of their major developments in central Minneapolis . . . which resulted in a major physical and programmatic linkage of their two facilities. More recently, the Citizens League has played a leading role in encouraging both the Metropolitan Health Board and the community hospitals to reduce what we found to be a substantial excess of bed capacity in the area; and, further, to slow down the rate of hospital capital expansion.
>
> It was a real shock, therefore, in the context of this community effort to restrain investment, to learn that the federal government -- through the Veterans Administration -- intends to do a $250-million replacement of its hospital in Minneapolis.
>
> We understand the law and the program and the tradition of the Veterans Administration, in providing hospital care . . . and, in addition, hospitals . . . for veterans. We recognize the importance of the Minneapolis hospital, in the Veterans Administration system. We appreciate that it has not had substantial reconstruction in the past thirty years.

> But it is important for the government to appreciate, from its side, the impact that such a decision to proceed with the reconstruction of the Veterans Administration hospital has, here, on the efforts other agencies are making to get this community to deal firmly with the need to reduce the size of its own hospital system. In effect, the federal government is declining to apply to itself the requirements for planning and coordination that it is requiring of the community system . . . since the Veterans Administration will not be submitting itself to the certificate-of-need process. We do understand that the Veterans Administration has asked the local health system agency to review its proposed plans, for program and for building. This will be helpful. There are some important questions arising about the relationship of the Veterans Administration hospital to the community system. One, of particular significance, has to do with its relationship to the proposal proceeding concurrently by the University of Minnesota for a $200-million replacement of University Hospitals, with which we know your hospital is closely affiliated, as a part of the teaching-hospital system.
>
> Some people are -- here, as nationally -- questioning why the Veterans Administration should operate a hospital system at all . . . since most veterans, most of the time, are users of the general community hospital system. We have not made this suggestion ourselves. But it does seem to us that the Veterans Administration hospital system would be more widely supported if the agency were to cooperate fully with the community in decisions about the size, shape and structure of the hospital system which serves it."

We never did have a reply from the Office of Management and Budget. We did have responses from the other agencies. A letter signed by the Chief Medical Director of the Veterans Administration told us that the existing building is deficient; that the VA is happy to cooperate with our local health planning agency, through the A-95 process; said that the VA is severely limited by law in its use of community hospitals for veterans -- limited, that is, to an emergency, until the veteran can safely be moved to a VA facility; and advised us that the Committees on Veterans Affairs and the Appropriations Committees of the Congress would perform a review of the project which will be "at least as, and maybe more, strenuous and critical than what is required of the private health care sector."

A letter signed by the Director of the Bureau of Health Planning in the Department of Health, Education and Welfare thanked us for our letter; advised us that a certificate-of-need is a state, not a federal program; said that the Secretary of HEW has concluded that there is no basis in law for requiring coverage of federal facilities in state programs; and told us again that the VA will be cooperating in an A-95 review.

Another response from the Administration thanked us for our letter; assured us that the government is firmly committed to controlling the skyrocketing costs of health care in the country; said that the VA hospital is badly in need of replacement; said that the money provided in next year's budget is only planning money; and assured us again that they will try very hard to keep costs down and avoid duplication of services.

Similar comments have been received, quite uniformly, from the offices of various members of the state's congressional delegation. Most commonly, there is reference to the VA's mission under the law to provide health care and hospital care for veterans -- in the sense of owning and operating its own hospitals. These assumptions appear to be accepted by almost everybody involved, with the exception of the National Academy of Sciences panel . . . which, of course, recommended that in a staged way, over a period of years, the VA program be merged into the general community hospital system in this country.

6. We have also read a good deal of the criticism of the NAS report, and heard it expressed orally in meetings and discussions around this community. It is perfectly clear, too, from this, what is a central misunderstanding involved. It is frequently assumed that the withdrawal of the VA from the operation of a hospital system would represent, at the same time, the withdrawal of the responsibility of the federal government for providing for medical and hospital care for veterans . . . thereby dumping this burden on other federal health care programs and/or on the health care programs of the states and localities, or the private sector.

   The NAS panel has said over and over again, and so clearly it should not be possible to misunderstand it, that it fully supports the entitlement given to veterans under the existing law, and is quarreling only with the question of the way in which that hospital care is provided, and by whom.

7. Like the other public agencies involved, the Metropolitan Health Board has also worked within the framework of existing law. The basic concept of the VA as a hospital system, rather than as an entitlement program, is not basically questioned. The document originated by the staff essentially quarrels only with the size of the hospital. It does, on page 30, discuss briefly, as an "alternative," the concept of the VA essentially buying hospital care in the community hospital market, but this notion is very quickly dismissed . . . with what we regard as a wholly inadequate analysis.

8. What is very clearly called for -- and required, for any effort to lay this whole question to rest -- is a serious in-depth look at the alternatives to the present VA mode of operation.

   It is clear this will not come from the Veterans Administration itself. Rather, it will have to be done by the parties on the outside.

   The NAS panel suggested that -- as a way to break out of this endless argument about continuing to do everything the same way, or doing everything a different way -- there be some community "demonstrations." Some experimentation . . . some tests . . . and that the question of what the VA program becomes, nationwide and longer-term, be settled not by discussion but by what actually happens when veterans are given the opportunity to react to a different system.

   What we propose is that Minnesota take the lead in organizing such a demonstration, as an extension of the discussion going on here currently.

   It does not appear realistic to expect that the process of planning that looks toward a whole new conventional hospital will be help up, pending the discussion of a possible alternative.

   But, especially considering the amounts of money involved, we think it is not unrealistic to suggest that, overlapping this period of planning, some effort be devoted to looking at a basic alternative, which would involve either the veterans individually or the VA as an organization, essentially buying into the hospital capacity that exists in the community system.

   This does not have to mean there would no longer be "a VA hospital" here in the

Twin Cities area. There could still be a building here (perhaps even a new building) that would be "the VA hospital." In it there would be VA personnel, to receive applicant veterans on precisely the same basis they are received today. Once admitted at the VA hospital, veterans are then taken to a place, on a floor of a hospital wing, where a bed is available for them. This could be in one building; or in another building. It could be on the grounds with the existing VA hospital; or it could be on a different site. It could involve a walking trip, or a driving trip. The study to design such a demonstration alternative should be, we think, funded by the Department of Health, Education and Welfare, through its division concerned with efforts at hospital cost control. The study should be conducted by the Metropolitan Health Board, in cooperation with the agencies that become responsible for the planning of the VA program and facilities.

The key persons in launching such a study, and in securing the funds for it, are, clearly, the members of the congressional delegation from Minnesota. We look to them for action.

Quite obviously, too, finally, any such study would require, at an early date, some indication from the hospitals in this community of the capacity they could, and would, make available, and the terms and conditions on which this would be done.

Testimony of

Harry Lemieux

TESTIMONY GIVEN AT THE PUBLIC HEALTH HEARING ON APRIL 30, 1980

Madam Chairperson, Members of the Health Board:

My name is Harry Lemieux, representing the United Veterans' Legislative Council of Minnesota. I serve as the Vice Chairman of the Council.

The United Veterans' Legislative Council is composed of representatives of sixteen (16) veterans' organizations and their auxiliaries in the State of Minnesota. These organizations represent over 50% of 548,000 veterans in the State of Minnesota

The organizations are:

American Legion
Disabled American Veterans
Fleet Reserve Association
Jewish War Veterans
Marine Corp League
Military Order of the Purple Heart
Minnesota Association of Concerned Veterans
Minnesota Association of County Service Officers
Minnesota National Guard
Naval Reserve Association
Pearl Harbor Survivors Association
Retired Officers Association
Spanish War Veterans

Veterans of Foreign Wars
Veterans of World War I
Vietnam Civic Council

All of these veterans' organizations are a special interest group. This Council, at the April 2nd meeting, voted unanimously in support of the Veterans' Administration request of 725 hospital and 120 nursing home beds for the Fort Snelling Regional Hospital. Let's first look at the hospital beds. January, 1979, there were 863 hospital beds. Today 738. They have already closed 125 beds, which is just under 15% of their total beds. Minnesota has more veterans today than ever before and to give up an additional 116 hospital beds is like taking a benefit away from the veteran. Statements have been made that only 20% of the veterans utilize the VA Hospital service, that is 109,600. There has been no support of this figure, and I have no idea how that compares with other hospitals. Should the bill, presently in Congress, to allow third party payment pass, that figure would double.

I retired as a Chief Petty Officer in 1966, and fortunately have not needed any hospital service, but should this happen, I would prefer the Veterans' Hospital over any metropolitan hospital. Presently, as a retired military personnel, I have Champus, which is a third party payee, and I cannot enter the VA Hospital. I'm very disturbed by this policy. As most of you know, I'm involved in long term health care. Most veteran residents in my facility, now and in the past, prefer to go to the Veterans' Hospital. This

pages tightly bound

means giving up their personal physician, but its still requested. Now lets talk about the 120 nursing home beds. The State of Minnesota will only allow 2.9 hours of nursing care per patient per day. The type of patients the Veterans Hospital has been releasing to nursing homes require much more care than we have available.

I believe with the type of nursing homes they are talking about, will allow for the additional care needed and for further transfer, after improvement, to a long term health care facility close to the veteran's home.

There is also problems with the VA contracts with private long term health care facilities. These contracts are for six months duration or less. The contracts, through no fault of the local Veterans' Administration, fall behind the Medical Assistance payments. This forces the long term health care facility not to accept the VA contract patients as it will cause the lowering of Medical Assistance contract rate.

Not only as a veteran, but also as a long term health care provider, I support the need for the VA Hospital and the 120 nursing home beds. Many of us here today feel that we have the full support of everyone when benefits are given during war time and for a short period thereafter. This is followed by a shaving of the benefits. We consider this, the shaving of our benefits. When we don't oppose, the benefits are shaved continually.

Health Board staff has recommended sharing of services with other hospitals. We support this aspect where this can legally and feasibly be accomplished.

I would like to encourage you to consider the VA Hospital as a regional hospital and not as a metropolitan hospital. Also, there are 548,000 veterans in Minnesota. The World War II veterans are reaching the period when they will need the care that this hospital will be able to give. I can assure you, should the Bill in Congress pass, allowing for third party payments, you will see increased utilization of the Veterans' Hospital.

I wish to thank you for allowing my testimony and hope you will see the need for the full request and support the veterans' organizations of Minnesota. Don't take this benefit from us.

Testimony of 4-30-80

Mike Ohnstad

STATEMENT OF THE AMERICAN LEGION AND THE AMERICAN LEGION AUXILIARY, DEPARTMENT OF MINNESOTA, TO SUPPORT REBUILDING THE VETERANS ADMINISTRATION MEDICAL CENTER - MINNEAPOLIS

Madam Chairman and Members of the Metropolitan Health Board:

My name is Mike Ohnstad and I am employed as Director of Rehabilitation for The American Legion, Department of Minnesota.

THE AMERICAN LEGION AND AUXILIARY.

The American Legion, congressionally chartered and organized in every state of the union, the District of Columbia and several foreign countries, is the world's largest organization of wartime veterans with more than 2,700,000 members, men and women, who have served honorably during World War I, World War II, the Korean Conflict and the Vietnam Era.

It is my privilege and responsibility this evening to speak on behalf of the more than 124,000 members of The American Legion and the more than 55,000 members of The American Legion Auxiliary in the Department of Minnesota.

RELATIONSHIP OF AMERICAN LEGION AND AUXILIARY TO VAMC.

The Minneapolis VAMC is very close to the heart of The American Legion and its Auxiliary, inasmuch as Rehabilitation of the sick and disabled veteran has been one of the principal purposes and primary programs of The American Legion since its founding over 61 years ago. Over the course of more than a half century of service, The American Legion and its Auxiliary have worked hand-in-hand assisting the Minneapolis VA Medical Center in its mission of providing health care to the needy veterans who have sought its service.

A new era is about to begin in the history of the VAMC in Minneapolis as we contemplate the rebuilding of the hospital. The VAMC is, and must continue to be, more than an assemblage of buildings and a collection of equipment. It is a living institution where the distressed seek relief from their illnesses and restoration of health when possible.

VAMC PROVIDES CARE FOR VETERANS.

The VAMC has two basic uncommon characteristics that distinguish it from local general or community hospitals: Its constituency and its catchment area.

CONSTITUENCY. The first distinct characteristic of the VAMC is its constituency. The Congress, in its wisdom, has seen fit to create and to continue, as a matter of public policy, a health care delivery system designed and designated for the unique needs of veterans. The American Legion supports that public policy.

CATCHMENT AREA. The second distinct characteristic of the VAMC is in its catchment area. Throughout the course of the month-long hearings of the Project Review Committee the idea was repeatedly advanced to identify the VAMC as another "community" hospital of the metropolitan area. We should like to point out that unlike any of the other metropolitan hospitals the VAMC's "community," if we must use the term, is not the Twin City Metropolitan Area, nor even the Minnesota area, but rather a medical region serving medical needs of the veterans of several states.

SUPPORT FOR REBUILDING.

It has been determined by the Veterans Administration that the physical plant at the VAMC Minneapolis must be replaced in order for the hospital to effectively and efficiently continue its mission of serving its constituency.

In matters affecting veterans, The American Legion claims the freedom to be either a critic or supporter of Veterans Administration policies and decisions. We are pleased therefore that in this instance we can commend the Veterans Administration for its thorough research and planning with regard to this present project.

The American Legion is not unmindful of the high costs of medical care and the desirability of cooperative relationships wherever feasible. The American Legion and its Auxiliary need no instruction in responsibility to "the community," for in every major city and the tiniest towns The American Legion and Auxiliary continue their service to the community, the State, the Nation and the world. I would draw the attention of this Board to the fact that The American Legion and Auxiliary of the Department of Minnesota have contributed one million dollars to establish an American Legion Heart Research Professorship at the University of Minnesota. I have also distributed a monograph that demonstrates that The American Legion, Department of Minnesota has been in the forefront of cooperative relationships with the University of Minnesota and the Veterans Administration for many years. We are committed to continue those cooperative relationships.

Having demonstrated and pledged ourselves to continuing community concerns in all appropriate areas, The American Legion is fully supportive of the Veterans Administration's plans to construct a new hospital with 725 beds and 120 nursing care beds. In so doing we affirm that The American Legion agrees with the public policy of this nation to provide and continue a separate and distinct health care delivery system for the unique needs of veterans.

CONCLUSION.

We believe that the Veterans Administration's decision to rebuild the VA Medical Center at Minneapolis is wise and warranted by objective facts and circumstances.

I thank you for the opportunity to indicate the position of The American Legion and American Legion Auxiliary of the Department of Minnesota with respect to this important project.

Testimony of

Lawrence Poston

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MINNESOTA MEDICAL ASSOCIATION
101 E. FIFTH STREET • ST. PAUL, MINNESOTA 55101 • AREA 612 PHONE 222-6366
HAROLD W. BRUHN, Executive Vice President

April 30, 1980

TESTIMONY ON THE PROPOSED REPLACEMENT OF THE VETERANS ADMINISTRATION MEDICAL CENTER IN MINNEAPOLIS, MINNESOTA

I am Dr. Lawrence Poston, a veteran and a family practice physician from Caledonia, Minnesota. I am speaking on behalf of the Minnesota Medical Association, as Vice Speaker of the MMA House of Delegates.

The Minnesota Medical Association has a long and active history in both cost containment and health planning activities. Our sponsorship of the Commission on Health Care Costs (composed of community, business, labor and medical leaders in Minnesota) and regional physician health planning groups such as the Physicians Metro Health Force, are representative of our commitment to cost effective quality health care. Our interest in health planning has, to date, been directed almost exclusively to plan development issues. We intend to maintain that posture in the future. However, because of the national importance we perceive for this issue, and the fact that we are dealing with a nation-wide health care system for veterans rather than a single hospital, the Minnesota Medical Association's Board of Trustees acted on April 19, 1980 to authorize the presentation of this testimony.

I will highlight some of the premises on which our testimony is based:

1. We recognize the Veteran's Administration Medical Center in Minneapolis as a valuable community and regional resource in the areas of teaching, research, and patient care. Locally, the coordination of teaching and research programs, especially between the University and the Veteran's Administration have benefited both veterans and the public in general.
2. We support the building of a new Veteran's Administration Medical Center at the Fort Snelling site in Minneapolis.
3. We support the availability of high quality, accessible cost-effective care for all veterans.
4. We support the rights of veterans to receive health care in the institution and/or setting of their choice.
5. Though we are skeptical of the cost effectiveness of the mandated Certificate of Need process, we support community involvement in all health planning decisions.
6. We endorse the concept of fair market competition among providers in health care, but we feel that such competition is fair only if all participants operate according to the same rules.

Beginning with these premises, then, I would like to address several in greater depth. In reference to the issue of quality, the operation of two separate systems for quality assurance has been an area of concern for Minnesota physicians for some time. Professional Standards Review Organizations (PSRO), the quality assurance system established by federal mandate for community-based hospitals have operated well in Minnesota to evaluate care provided against pre-determined norms. Special emphasis has been placed on the areas of appropriateness of admissions and length of stay. The parallel, but separate review system of federal hospitals does not allow for the evaluation of care delivered in those hospitals against community-based norms. This calls into question two dual issues of quality and cost. The VA system has long recognized the need to affiliate with University/teaching centers as a method for improving access to quality care. It is only appropriate to strengthen that link to community-based care through the joining of both quality assurance programs. We urge Congress to authorize a pilot project in the Twin Cities area in which the Minneapolis Veteran's Administration Medical Center could voluntarily participate and reimburse the local Professional Standards Review Organization for quality assurance reviews. If successful, the experience of such a joint project between the Minneapolis VAMC and the local PSRO could stand as a model for replication nation-wide.

With regard to health care cost containment, the number of beds projected in the Minneapolis VAMC proposal, the projected building cost, the equipment costs, and the anticipated operating costs for the proposed facility are substantial indeed. Private hospitals in the Twin Cities metropolitan area and throughout the state have worked hard in their own voluntary effort program and in cooperation with the state's Health Systems Agencies to reduce the number of hospital beds and impact favorably on rising health care costs. The magnitude of the VA proposal dwarfs this voluntary effort, and may, in fact negate the gains made by the private sector to date. Yet, because of federal legislation, the Veteran's Administration proposal has been exempted from the normal community review process which all other hospitals undergo when they propose construction, renovation, equipment purchases, or service expansion. This artificial separation between federal and local delivery mechanisms makes a sham of our local, regional, and national planning efforts. While we are skeptical of the cost effectiveness of the mandatory Certificate of Need process, it nevertheless recognizes the interdependence of all parts of the health delivery system and allows for community input and involvement in health planning decisions. We contend that the proposed Veteran's Administration Medical Center is a part of, and not separate from, the overall health delivery system in the metropolitan area and throughout its service area. Actions taken by this facility will significantly impact on all other metropolitan, outstate, and out-of-state hospitals. In fact, to maintain high occupancy in this very large federally funded facility, the VA may move more aggressively into marketing to veterans with non-service related disabilities who might otherwise receive care in a community hospital. In terms of cost containment, we feel the impact will be a negative one. We, therefore, call on Congress to seriously consider all community testimony provided in this premptory A-95 review of the Minneapolis VAMC proposal, and to rethink the federal position of exempting federal proposals from local community planning processes.

Referencing our support of the right of veterans to accessible health care and to receive that care in the institution and/or setting of their choice, we perceive that the size of the proposed facility will act as a disincentive to responsible, decentralized, deinstitutionalized health care delivery to veterans. Non-veterans receive care in hospitals in or near their own home communities. Yet many veterans, in order to receive their veteran's benefits for health care, must travel substantial distances (even across state lines) to the Minneapolis VAMC at considerable inconvenience to themselves, their families, and friends. We recognize this travel as appropriate when tertiary care is imperative. Yet it seems contrary to energy conservation policies and good medical practice to require such a substantial commute for care which could otherwise be appropriately provided in closer proximity to the veteran's home. In this sense, then, the veteran may be receiving second-class care. The trend toward "deinstitutionalization" of services, or the delivery of a number of services (such as mental health and chemical dependency) in community-based, non-hospital settings is also an option foreclosed for veterans by virture of the construction of a large facility in which those services are to be provided. We call on Congress to authorize the building of a substantially smaller VAMC facility in Minneapolis and to study the feasibility of reimbursing community-based facilities for care provided to eligible veterans.

Finally, we endorse the concept of fair market competition among health care providers, but emphasize that such competition can be fair only when all players are expected to abide by the same rules. As noted elsewhere in our testimony, we urge the Veteran's Administration Medical Center in Minneapolis to consider itself to be a part of, rather than separate from, the network of hospitals in the metropolitan area and throughout its service area. We urge Congress to act to ensure this systems approach, particularly with regard to a pilot project between the VAMC and the local PSRO, and the incorporation of all federal projects into the community review process for health planning decisions. Finally, we urge the Congress to give serious consideration to the authorization of a much smaller facility than the one currently proposed at the Fort Snelling site. My colleague, Dr. Stuart Hanson of the Physicians Metro Health Force, whose testimony follows, will address the issue of bed sizing metholologies in addition to the impact which the building of the proposed facility may be expected to have on the metropolitan area facilities.

I would like to thank you for this opportunity to comment on this important issue. If you have any questions, I would be pleased to respond to them at this time.

Testimony of

Stuart Hanson

PHYSICIANS METRO HEALTH FORCE

900 American National Bank Bldg. St. Paul, Minnesota 55101 • 612 222-6366

A. Stuart Hanson, M.D., Chairman

April 30, 1980

TESTIMONY OF THE PROPOSED REPLACEMENT OF THE VETERAN'S ADMINISTRATION MEDICAL CENTER IN MINNEAPOLIS, MINNESOTA

My name is A. Stuart Hanson, M.D. I am a practicing physician in this community, and Chairperson of the Physicians' Metro Health Force, which represents the metropolitan area physicians in health planning. I am a Vietnam veteran whose background includes clinical training at this area's Veteran's Hospital and the University of Minnesota.

The Physicians' Metro Health Force has previously centered its efforts in the plan development area of Health Systems Agency activity. We have felt that our participation with the Metropolitan Health Board to develop well-conceived community plans, which take into account the community needs for quality, cost-effective care, would preclude our extensive involvement in the regulatory activities of the Health Systems Agency. However, we are now faced with a proposal for large capital expenditures on the part of a regional health-care facility which has not participated in the community health planning process. Because of this unique circumstance, the Physicians' Metro Health Force decided to publicly present our comments on the proposal to replace the Minneapolis Veteran's Administration Medical Center.

I would first like to present some of the assumptions underlying our testimony:

1) We agree that a new VA Medical Center should be built.
2) We agree that this new hospital should be at the Fort Snelling site.
3) We recognize that the VA is a regional referral center with 50% of all hospital discharges from the metropolitan area, and 88% originating from Minnesota.

Representing Physicians of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington Counties

4) We also agree that Veteran's should have the right to choose where they receive their care. Whether they choose the VA or the community-based system of care, there should be no built-in bias or prejudice for use of either system.

5) We agree that all patients should receive quality care, regardless of who pays for it or where it is delivered.

6) We recognize the unique contributions of the VA Medical Center in the areas of research, teaching and patient care. These efforts should be recognized, encouraged, and publicly applauded. However, we believe that their efforts must be coordinated with other community programs to reduce unnecessary duplication and expenditure of federal funds.

7) We agree with and have fully supported the concept of community review for all health care facilities. Even though we have reservations about the efficacy of the Certificate of Need process, it is the best we now have available.

Our concern for high quality, cost-effective care demands that we raise a number of comments about the Minneapolis Veteran's Administration Medical Center proposal.

Our primary concern stems from our dedication to the delivery of high quality medical care. Essentially, all patient stays in metropolitan area hospitals are reviewed via a system which assesses the necessity of admission, length of stay in the hospital, and the appropriateness of treatment. This program, developed by the Foundation for Health Care Evaluation seeks to assure that only those patients needing hospitalization are admitted, and then only for the length of time for which they need acute care. Patient stays in Veteran's Administration Medical Centers nation-wide are exempt from this type of community review. Instead, they have developed their own federal program of a similar nature. It is clear that the Veteran's Administration system recognizes the importance of patient review. However, it seems inconsistent for the VA to develop a parallel system for review of its patients without utilizing the resources available to it in the community. This leads to two major questions: 1) Are all the patients admitted to a VA acute care bed admitted appropriately? and, 2) Are those patients who are appropriately admitted being discharged, or transferred to another level of care on a timely basis when medically indicated?

We would propose that the answers to these questions be determined through the pilot project funded by the National Veteran's Administration whereby, the Foundation for Health Care Evaluation would provide its peer review services for Minneapolis Veteran's Administration Medical Center patients.

The remainder of our testimony addresses the bed size and specialized services offered or proposed to be offered within the new Veteran's Administration facility. We would first like to list some of the factors affecting the size of the Veteran's Administration Medical Center, provide our critique of the GAO hospital bed sizing methodology, and finally, provide some of our own estimates of bed capacity. We perceive that the following factors will affect the size of the facility:

1) The extent to which the VA provides services to persons with non-service related disabilities.

2) The extent to which veterans who are age 65 or over will choose the VA Hospital for their health care, rather than community hospitals reimbursed through Medicare.

3) The impact of the change in treatment modalities to bring VA admission and length of stay patterns within community norms.

4) The availability of community-based, VA funded alternatives for care nearer to the veterans home community. For example, what impact would de-centralize, community-based mental health services have on the utilization of the VA Hospital?

The GAO methodology used to project 745 beds for the new facility (619 were acute care beds, 86 non-acute care beds, and 40 nursing care beds), seems to inflate the need for acute and non-acute care beds. Although the GAO methodology attempts to account for the VA's extra long length of stay by using community norms for length of stay, the methodology fails to assess the necessity of the admission. Additionally, the GAO model does not address future changes in lengths of stay, and no trend analysis was incorporated. All these factors tend to overstate the acute care bed need.

We are also confused about the method used to generate the projection for non-acute care beds. Under the GAO model, as the need for acute care beds decreases, the demand for non-acute care beds increases. The need for non-acute care beds should have been provided directly. The GAO methodology does not seem to take into account where in the patient stay, the non-acute care days are needed, and for how long or if the patient should have been admitted directly to a non-acute or acute care service. Another factor which seems to mitigate against the use of non-acute care beds is their proximity to the acute care beds. We understand that these beds, in many cases will be in the same nursing station as the acute care beds. Thus, there will be a minimal incentive for transferring patients to areas with lower levels of staffing as the patients needs for care decreases. However, there will be a strong incentive to treat acute care patients in the non-acute care beds because of the proximity of skilled nursing care, equipment and other needs of acute care patients. Since the burden of proof to show need rests with the applicant, additional information showing need for these non-acute care beds would be desirable.

Estimating a facility's bed need is, at best, an inexact science and at worst, an expensive mistake. However, there are some rules of thumb generated from studies which can serve as a point of departure and adjustment. While we feel no method is ideal, and no one can make a definitive case in an oral presentation, estimates which tend toward a central number provide some justification for a final recommendation.

The starting point for our analysis on the proposed bed size for the VA Hospital, is to review federal and state expectations of a maximum of four acute care hospital beds per 1,000 population. Assuming that the VA Hospital system serves 20% of the veteran population within its service area, a rough calculation based an estimate of the relevent population in 1995 projects a need for 401 acute care beds. However, upward adjustments must be made for the large percentage of elderly person which the VA serves, in spite of the duplicating health insurance coverage for this population. We generally agree with the approach and analysis of the Health Board staff in this regard to accommodate for the care needs of the 65+ age roup. Additional consideration should be given because the Minneapolis Veteran's ministration Medical Center is a referral facility. An additional 20 beds could e added to the hospital's bed complement to account for hemodialysis care and the riatric, Research, Education and Clinical Center. This would bring the total ospital bed complement to 442 beds (exclusive of the nursing care beds).

Since the simple-minded approach of applying national guidelines to generate ospital bed size is incomplete, other methodologies must be utilized to verify or unter-indicate the projection derived from the national guidelines approach.

In an analysis performed for the Health Board's review committee, 493 acute spital beds were recommended. This included an adjustment by the Health Board or the high use of hospital facilities by older age population served by the VA.

To this base-figure, there could be added 20 beds for hemodialysis and the riatric, Research, Education and Clinical Center. This results in a total bed mplement of 513 (exclusive of nursing care beds).

Thus, we could recommend a range of from 442 to 513 beds in the hospital.

In reference to the nursing home beds, we agree with the Health Board's preliminary recommendation of 40 beds. However, because of the increasing need or long-term nursing beds for the aging VA population, we would support the VA rking with other community providers to continue to provide and enlarge the ntinuum of care available for veterans through the utilization of existing mmunity resources and programs.

The parallel development of the VA and University of Minnesota projects allows oth institutions to "design-in" certain sharing arrangements. With regard to nsolidation of specialized services, we would support the Health Board's preliminary commendation to consolidate renal transplantation services and megavoltage adiation therapy services at the University of Minnesota Hospital. However, we lso feel, based on the similarities betwen the two facilities in their teaching, research, medical staff, and patient care programs, that other sharing arrangements re feasible. We would encourage continued discussions of possible areas of con-solidation.

The recommendation that a smaller VA Hospital be built might be seen as a retrenchment of our responsibility to care for our nation's veterans. However, a smaller, more efficient VA Hospital may serve veterans better by allowing the development of more community-based health programs for veterans, by allowing the veteran to choose where he wishes to receive care, and by reducing the potential duplication of health care coverage for veterans over 65 years of age. Thus, the country can fulfill its responsibility to serve the veteran with high quality medical care while minimizing a disruption to his personal life while he is in ill-health.

I appreciate this opportunity to speak with you today and would be happy to try to respond to any questions you might have.

Thank you.

Testimony of

John O'Neill, Jr.

DEPARTMENT OF MINNESOTA
VETERANS OF FOREIGN WARS
OF THE UNITED STATES

BOX 17146, RICE ST. STATION
ST. PAUL, MINNESOTA 55117

[illegible]

VETERANS SERVICE BUILDING
ST. PAUL, MINNESOTA 55155

[illegible]

April 30, 1980

Metropolitan Health Board

On April 1, 1980, I attended the Citizens League Breakfast in Minneapolis which discussed the proposed Minneapolis Veterans Administration Hospital. In the presentation there was reference to an article by Ann Sullivan of the Oregonian staff entitled "New VA Hospital opposed in poll".

The article told of a telephone survey to 310 veterans in the northern Oregon and southern Washington which indicated that three fourths of those veterans preferred hospitals and other medical services rather than the Portland VA Hospital.

The article further noted that 80% of the veterans polled did not belong to a veterans organization. Because of the Oregon survey, we decided to do a survey of the veterans in Minnesota and have a completely opposite answer.

Our survey was completed within the last two weeks among 987 veterans, mostly those who had served overseas. These veterans said they would prefer the VA Hospital system by 94.02% in fact some of the 5.98% of the veterans who declined using the VA Hospital noted that they didn't care for the old buildings and the ward system.

Of the veterans polled in Minnesota, 265 did not have group hospitalization coverage. We asked this question because it is the only affordable type hospital and medical insurance coverage.

In Minnesota, nearly 82,000 veterans belong to the Veterans of Foreign Wars. Based on various guestimates of eligible veterans, this accounts for 28 to 33 %. Our national headquarter claims 28.09% while we maintain that it is closer to 33%.

The Veterans Administration Hospital had 1,100 beds in 1965 and had the foresight to reduce to the 725 proposed in the hospital being considered for replacement. We feel that we cannot accept an further reduction of beds. We also feel that the 120 acute care nursing beds are a necessary addition to the hospital and should not be reduced. In closing I would like to point out several items on the enclosed sheets.

Sincerely,

JOHN L. O'NEILL, JR.
Adjutant-Quartermaster

"HONOR THE DEAD, BY HELPING THE LIVING"

Veterans of Foreign Wars Statistics

Furnished by John Senk, Reasearch & Development Director
Veterans of Foreign Wars of the United States
34th and Broadway, Kansas City, Missouri 64111

State	Veteran Population	War Veteran Population	Estimated V.F.W. Eligible	V.F.W. Members	% of Eligibles
Minnesota	558,000	484,000	290,400	81,560	28.09%
Oregon	382,000	336,000	201,600	15,383	7.63%
Washington	609,000	532,000	319,200	30,604	9.59%

In a survey conducted by an Insurance Company last year that mailed out 7,600 questionaires to VFW members, 1,558 replies were received with the following information:

Total Family Income:

Under $5,000.	4.3%
$5,000. to $10,000.	13.0%
$10,000. to $15,000.	25.0%
$15,000. to $20,000.	1.9%
$20,000. to $25,000.	24.0%
$25,000. to $30,000.	11.5%
$30,000. to $35,000.	16.5%
Over $35,000.	3.8%

Additional information on members of the Veterans of Foreign Wars (1979 survey)

85.6 % are married

88.0% have families averages 2 to 4 children

43.1 % of the membership are in the 55 to 64 age bracket

14.0% of the membership are in the over 65 age bracket.

4/28/80 JOM)

Results of study made of mostly members of the Veterans of Foreign Wars by questionaire distributed throughout Minnesota during April, 1980. The questionaire was titled "Would you use the Minneapolis (V.A.) Veterans Administration Hospital?".

Age brackets	Would you use the Mpls. VA Hosp.			V.A. Disability	Hospital last Two Yrs.	Ever In VA Hospital	Satisfactory		No Group Hospital Insurance
	Yes	No	Total			Yes	Hosp.	Medical	
27 to 40	168	13	181	41	33	49	48	45	50
41 to 51	186	10	196	28	38	49	48	48	38
52 to 62	398	31	429	131	114	161	158	158	98
Over 62 Yrs.	176	5	181	63	64	82	79	78	79
TOTALS....	928	59	987	263	249	341	333*	329	265
	94.02%			26.64%	25.22%	34.54%			26.84%

*Several notations on those who didn't consider the hospital service satisfactory noted that the buildings were too old and the conditions crowded.

Testimony of

Lyle Pearson

PRESENTATION TO METROPOLITAN HEALTH BOARD
April 30, 1980

L. Pearson

I am appearing here today as the representative of the Disabled American Veterans of the State of Minnesota and of the adjoining states who utilize the services of the Ft. Snelling Veterans Administration Hospital.

As such the DAV represents veterans who are the largest users of the VA hospital system...and it is as the consumer of services that we appear here today....We feel that we are speaking as the consumer advocate, and as such we have a vested interest in the VA hospital system and anything that bears on this system.

My assumption is that I am here today to respond to the alleged position of the MHC regarding the building of a new VA hospital in the Twin City area, that position being to reduce the size of the projected new hospital, to merge some of the programs with the U of M hospital system, and to merge services with other private hospitals in the metropolitan area.

The matter of the new hospital site was an area of discussion, and let me say that we are unalterable opposed to any suggestion that the new VA hospital be built anywhere but on the present hospital site. The accessibility of the present site would preclude any thought of moving the hospital to the U of M area. The present site is close to the Twin City International Airport, easily accessible by private car and close to the outpatient clinic. There is ample parking on the present site, and this is particularly important to the continued operation of the Veterans Administration Volunteer Service program. Volunteers will not volunteer their time at a facility where they must walk long distances to get to their volunteer stations.

In the area of the suggestion that the VA hospital be reduced in size and that they merge services with metro area medical centers..... we categorically reject these suggestions.....We feel that the Metropolitan Health Council has completely overlooked the fact that this VA hospital is not a metropolitan area facility....it is a facility to care for certain veterans throughout the state of Minnesota, and the adjoining states of Wisconsin, South Dakota, North Dakota, Iowa, Montana and Wyoming.

by the State Planning Commission

We recognize the fact that the metro area hospitals are very likely overbedded -but I do not think that the VA hospital system should be used to solve that particular problem......

We are only interested in the best care for the veteran who need hospitalization and we think that this care can only come from a VA hospital system that was established by a grateful nation to care for those answered the call to serve their country in time of peril....and we strongly resist any attempt to interfere with the operation of this system by outside agencies, or to dilute the system with non veteran patients to the point where the system can no longer be considered a medical center for the treatment of war veterans.

We feel that the VA hospital system with all the handicaps it has been operating under for the past few years,,, is still the system that understands the unique problems of the veteran and can best address themselves to these problems......

We commend Dan Conway and his staff for the fine job they are doing at the Ft. Snelling VA Medical Center...and we feel that any attempt to shift medical care from the VA hospital to a private facility would result in a lessening of services and certainly no more cost effective....

And so the position of the Disabled American Veterans is the same as it was on April 8 of this year at a meeting before the Senate Veterans Affairs Committee.... at that time we supported the construction of a new VA medical center on the grounds of the present facility.....that this medical center be of an 845 bed size with 120 beds for skilled care nursing patients to allow for the many younger veterans needing care for serious disabilities and the aging World War II veterans who require hospitalization in increasing numbers./ We will ask the Congress to appropriate $15 million in Fiscal Year 81 for start up money, and ask that the funding actually needed for hospital construction---some $200 million ---be appropriated in later fiscal years. We will also request sufficient funding to furnish and equip this new facility. Projected completion date at this time is 1987, and by this date we expect that the demands of the veteran population in this area will fill this medical facility to overflowing.

Testimony of

Joseph O'Neil

East Metro Hospitals Trustees Council

The East Metropolitan Trustees Council feels that construction of a new Veterans Hospital in the Twin Cities area is a matter of considerable concern. Replacement of a major unit in the metropolitan area at a time when there is general agreement that the other hospitals have an excess number of beds requires careful review before final plans are made for new buildings.

We appreciate the willingness of the Veterans Administration to submit its plans to the Metropolitan Health Board for review and hope it will result in coordination of care for all metropolitan area patients. We recognize that while some Veterans Administration patients could appropriately be cared for in other hospitals, there are also some types of cases those hospitals might prefer not to handle.

However, we think that if another Veterans Hospital is needed, care should be exercised to avoid construction of duplicative facilities and to arrive at maximum benefits from the longstanding association with the University of Minnesota Hospitals.

Could not some savings be realized by sharing of services between the Veterans Hospital and the University of Minnesota which is also considering a new facility? The close teaching relationship between the two institutions would seem to offer special opportunities for both of them.

For example, why not consider an "H" shaped facility with each leg housing beds for the two institutions and a connecting unit for offices, classrooms, laboratories, radiology and other supporting services common to both. Such an arrangement ought to save time and money in travel and communication expenses as well.

We also wonder if it is appropriate that the Veterans Hospital for the first time build and operate their own long term care facility in an area such as the Twin Cities when veterans long term care needs could be adequately well served by the existing system.

As the Veterans Administration is a major provider of services to metropolitan area residents, we would also like to have its long range plan submitted periodically to the local HSA as is done by other hospitals in the area.

We applaud the efforts made to date toward finding a less expensive approach and urge further such efforts. If we can be of any help, please feel free to call upon us.

April 30, 1980

pages tightly bound

TESTIMONY BY DONALD M. MILLER

COMMISSIONER OF VETERANS AFFAIRS

STATE OF MINNESOTA

My name is Donald M. Miller, Commissioner of Veterans Affairs, State of Minnesota. I appear before this group in support of the Veterans Administration proposal to build a replacement hospital on the present site in Minneapolis. I am satisfied the V.A. has adequately studied the needs of the eligible veterans in the seven state area this facility serves.

The 725 beds is approximately the same as the existing 738 beds and is a marked reduction in beds available to veterans twenty years ago. The proposed 120 intensive skilled care beds will help alleviate the present problem of V.A. Hospital discharging patients who are not completely recovered. The medical staff at the Minneapolis Campus, Minnesota Veterans Home, has reported many incidents of patients with elevated temperatures and other problems who have been returned to Veterans Home due to the pressure of the V.A. needing the bed.

Our State Veterans Homes care for veterans in all eighty-seven counties of this state. When the veterans enter our Homes, they are then identified as from Hennepin or Dakota county, even though they may have been long-time residents of Nobles or Marshall county. As a result, the applications for V.A. hospital care, in many instances, discloses the veteran as from Minneapolis or Hastings, when, in reality, the veteran is from out-state Minnesota.

Our Department of Veterans Affairs has enjoyed a long-standing program of inter-change of services with the staff of the Minneapolis V.A. Medical Center. They provide the acute hospital care and rehabilitation services while we, on a very limited basis, provide skilled and intermediate nursing care and domiciliary care for Minnesota's veterans. Presently, the V.A. reimbursement formula authorized Minnesota's Veterans Homes to have 1300 nursing care beds. We presently have 181 nursing care beds at Minneapolis and 250 new construction nursing care beds should be available in the Fall of 1980. We have a total of 540 nursing care and domiciliary beds in Minneapolis. These identified nursing care beds total 431 and leave a remainder of 109 domiciliary beds after the completion of the new building. In addition, we operate a licensed 200 bed domiciliary at the Hastings Campus.

I believe the people of the United States have set a policy "to care for him who has borne the battle". I am proud that Minnesota has a long record of support for their veterans and the proposed V. A. Medical Center is a must to ensure Minnesota's veterans will receive the best care humanly possible.

In closing, I would like to include, for the record, a copy of a letter written by Governor Quie to Senator Durenburger. I am also providing a letter I have received from Mr. Lloyd Zander, Commissioner of the North Dakota Department of Veterans Affairs.

ALBERT H. QUIE
GOVERNOR

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
ST. PAUL 55155

April 30, 1980

The Honorable Dave Durenberger
Member of Congress
353 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Dave:

This is to inform you of my support for construction of a new V.A. hospital to replace the existing hospital in Minneapolis. It is my understanding that the Veterans Administration has conducted extensive reviews of various proposals for upgrading the medical facility - and has concluded that the construction of a new facility is in the best interests of the federal government.

As you are probably aware, the Minneapolis V.A. Hospital currently ranks as one of the top V.A. hospitals in the nation in education and training as well as research programs. It has been estimated that over one-half of the physicians who receive their training at the Minneapolis V.A.M.C. remain in Minnesota to practice medicine. Thus, the V.A.M.C. stands as a resource to the State of Minnesota as well as a much needed medical facility for the veterans of the upper midwest.

For these reasons, I strongly support construction of a replacement facility at this time. Any delay in this program could have a detrimental effect on this project. Recently, the House Committee on Veterans Affairs notified the Speaker of the House that it approves the V.A.'s construction plans. Your support of this project throughout the appropriations process would be much appreciated.

Best wishes.

Sincerely,

ALBERT H. QUIE
GOVERNOR

AHQ:vrl

TELEPHONE [illegible]

STATE OF NORTH DAKOTA
DEPARTMENT OF VETERANS AFFAIRS
[illegible] - 4TH AVENUE NORTH P. O. BOX [illegible]
FARGO, NORTH DAKOTA [illegible]

LLOYD F. ZANDER - COMMISSIONER
[illegible]
[illegible]
[illegible]

April 28, 1980

Mr. Donald Miller
Commissioner
Department of Veterans Affairs
State Veterans Service Building
St. Paul, MN 55155

Dear Mr. Miller:

It is our understanding that a new Veterans Administration Medical Center replacement hospital has been proposed for Minneapolis and that the cost of this replacement hospital has been recommended in President Carter's 1981 budget to the Congress.

Speaking on behalf of the North Dakota Department of Veterans Affairs, we support this project. Not only will it be an asset to veterans in your State, it will also benefit veterans in the State of North Dakota. Veterans from our State are often referred to the Minneapolis Veterans Administration Medical Center for specialized examinations and treatment that cannot be accomplished at our Fargo Veterans Administration Medical Center.

It is our hope that the building of a new Veterans Administration Medical Center in Minneapolis will become a reality in the not too distant future.

Kindest personal regards.

Sincerely,

Lloyd F. Zander
Commissioner of Veterans
Affairs

LFZ:dra

RECEIVED
APR 30 1980
Dept. of Veterans
Affairs

STATE OF MINNESOTA
DEPARTMENT OF MILITARY AFFAIRS
OFFICE OF THE ADJUTANT GENERAL
VETERANS SERVICE BUILDING
STATE CAPITOL
SAINT PAUL, 55101

April 30, 1980

Mr. Donald M. Miller
Commissioner of Veterans Affairs
Veterans Service Building
St. Paul, MN 55155

Dear Commissioner Miller:

The Minnesota Army National Guard regularly utilizes the facilities of the VA Hospital, Minneapolis, for emergency medical care for individuals injured or who become seriously ill while performing military duty. This medical care is extended to all such personnel on an emergency basis within the metropolitan area, and to all personnel determined by proper medical authority to be in condition to withstand transportation to that facility from throughout Minnesota.

That facility also provides continued medical care to all individuals injured in line of duty on an outpatient basis from anywhere within the State.

During calendar year 1979 over 160 individuals were injured or became seriously ill which was determined to have been incurred in line of duty by the Department of the Army. Of those personnel, approximately 30 were hospitalized as in-patients at that facility, and many more received follow-up medical care as outpatients.

The service provided by the VA Hospital, Minneapolis, has resulted in a savings of undoubtedly hundreds of thousands of dollars to the U.S. government. In addition, the service provided was of the finest available anywhere.

The state presently has 57 individuals on active duty under Title 32, U.S. Code, and approximately 38 Active duty for training personnel (Title 10) on the full-time recruiter force, with personnel being rapidly added. Those individuals and their dependents are entitled to medical care at Government expense. With the present facility, only emergency medical care is available to those members, and no medical care of dependents is available.

I would like to express our need and the importance of a new facility which would provide full medical care for all the individuals mentioned above, to include dependents, which would result in a tremendous savings to the U. S. Government.

Sincerely,

D. S. MICHAUD
LTC, GS, MN ARNG
Chief of Staff

Testimony of

Richard Frey

MINNESOTA COALITION ON HEALTH CARE COSTS

JAMES B. KENNEY, Ph.D.
EXECUTIVE DIRECTOR

SUITE 401, 20 WASHINGTON AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55401

PHONE: (612) 340-0070

TESTIMONY TO METROPOLITAN HEALTH BOARD REGARDING THE PROPOSED VETERANS ADMINISTRATION HOSPTIAL, APRIL 30, 1980

Madame Chairperson, members of the Board, Collegues:

The Minnesota Coalition on Health Care Costs is a newly formed non-profit organization that has brought together private and public forces, dedicated to improve the cost-effectiveness of all levels of health services in Minnesota. Our Board of Directors, including business leaders, a variety of health providers, public and consumer representatives, met this morning to advance further initiatives for cooperative, voluntary action that will result in lowered health costs and improved accessibility for Minnesotans and our neighbors.

We are aware that the issues and questions raised in relation to the proposed new V.A. Hospital invoke concerns on the part of veteran representatives for a potential loss of veteran health benefits. We wish to clearly indicate that we are not addressing the question of continuation and improvement of health benefits and services, per se, for veterans. Our recommendations, we firmly believe, will lead to improved cost-effectiveness and health care for veterans and non-veterans alike without the sacrifice of quality.

These are times when our general economy and our need for coordinated health planning dictate that we must be open to new ways of doing things, of delivering services, and not be bound to a retrenchment and gradual reduction within traditional delivery structures. The need for coordinating public and private planning and services has never been greater. If we are to fulfill our health care responsibilities to all citizens, including those who are unserved and underserved as a result of finite health resources, we must capitalize on every opportunity to improve health planning across government levels and between private and public sectors. Unilateral

-2-

independent action frustrates a coordinated community plan.

We specifically recommend that the proposed plan for replacing facilities at the V.A. Hospital not only be submitted to existing planning agencies for review and comment but that the final recommendations of a coordinated planning process dictate the extent of public funding. Our need to promote the most cost-effective care within the limitations of both private and public resources must not be subordinated to specific interests at the expense of the common good.

We urge that every effort be made to convey this spirit of community responsibility to our Minnesota congressional representatives. Our organization stands ready to assist you with this process.

Richard J. Frey

Richard J. Frey, M.D.
Chairman of the Board
Minnesota Coalition on Health Care Costs

Testimony of

John Tonneson

opinion

HEALTH BOARD OF THE METROPOLITAN COUNCIL

[illegible] of members of the Metropolitan Board

Each year the number of beds available in the Veterans Hospital becomes fewer. It is not that the needs become lesser, but that the budget is reduced. In as much as the VA Medical Center in Minneapolis is for a 72 county and an eight state area, a 649 bed unit is much too small. Many patients who have completed necessary hospital medical and surgical care still need part-time nursing care that can be handled only by experienced personnel.

In the late forties and early fifties people were asked to donate monies for a period of three years to build additions to the so called private hospitals and one of the pitches to veterans was that there was not enough room for patients who were not service connected for their ailments. Now suddenly we have a surplus of beds in the private sector and the hospitals would like to use these extra rooms for patients who are veterans.

The cost of transferring these patients and their records would be, I am sure, quite extensive. It would disrupt the continuity of treatment and at the same time would not benefit the patient in his recuperation. It seems that the Dean's Committee at the Universities and hospital associations are out to reduce the VA to a shell or close it entirely. Could it be that the VA hospitals operate at a cost of 80% o f regular hospitals be the reason. What would happen in a case of disaster? I am not speaking of war but of a natural conditionswhere our National Guard and Reserves are called out to aid and assist. Military personnel are required to go to the nearest government medical center. If we don't have the medical facilities to take care of our present service connected veterans, how in the world would we be able to handle an emergency.

Many service connected outpatient veterans wait hours and hours for an examination and in many cases do not receive the treatment that is needed for their particular ailment. The Dean's Committee was asked to work with the VA and once they got their foot in the door, they are forcing it all the way open. The Metropolitan Health Board Committee is now proposing to use its power or influence to reduce the size of the VA Hospital in which only half the patients, if that many, come from the area that they supposedly represent. On Sunday, inthe ward that I visited, I met two veterans from

Iowa, [illegible] from Albert Lea, 2 from Grand Rapids and one from Chamberlain,SD. I am wondering what these veterans would say about your telling them that you want to reduce their chances of becoming a patient for the care that they need.

The VA Medical Center has a great financial impact on this area and yet with the great number of volunteers we are able to keep the overall cost down. Veteran's organizations have aided the VA Medical Center in securing medical equipment and supplies that the VA would not purchase, such as TV's, sliding doors, entertainment to the recovery process and many other items. From a hospital of over 1,000 beds to budget a proposed 725 bed and 120 bed nursing section, is more than the 10% cut you propose. Although I was born and raised in Minneapolis, I do not feel that we, as city folk, should force our ideas on people who live out side the Twin Cities.

Testimony of

Lynn Kiehne

COUNCIL OF COMMUNITY HOSPITALS
SERVING THE SEVEN COUNTY METROPOLITAN AREA

COCH COMMENTS ON VA HOSPITAL PROJECT

My name is Lynn Kiehne, and I'm speaking on behalf of the Council of Community Hospitals, an organization serving the thirty-five public and private community hospitals located within the seven county metropolitan area of Minneapolis and St. Paul.

Before I address our major concerns regarding the proposed VA Hospital replacement project, I would like to take this opportunity to commend the Metro Health Board's project review committee and its staff for doing a thorough analysis, given the short time it had to review a project of this size and scope.

My comments tonight will address two major concerns. Briefly, these are (1) the veterans should not be deprived of the opportunity to seek care at the facility of their choice, and (2) Federal hospitals should be subjected to the same government scrutiny and regulation as community public and private hospitals.

We appreciate the traditional role Veterans Administration Hospitals have had, and the need they filled at a time when our nation did not have enough hospital beds to handle those wounded during wars, as well as, other veterans who required extended hospital care. In 1923, when the VA was established, our legislators correctly understood the nation's continuing obligation to provide health care to those who fought its wars. Since adequate facilities were not available, the Federal government filled a need by building the VA Hospital system.

But in the 1940's, when Hill-Burton money first became available, communities across the country built hospitals with funds from the same Federal government to serve all of their populations without regard for whether they were veterans. Now in the 1980's there is the capacity in the private and non-Federal public hospitals to handle much of the veterans needs. This is not to say we do not believe there is a need for the replacement VA Hospital -- it merely questions the size and scope of such a facility under assumptions which perpetuate a system that forces many vets to use a separate facility, and does not provide them with the means to use the facility of their choice.

At the end of World War II veterans were granted educational benefits. However, Congress in its wisdom, chose to provide this benefit through the existing educational system. It did not set up 172 VA Universities across the country. Had we chosen to build the vets a separate educational system, today we would be facing extreme excess capacity. Would we also have chosen to perpetuate the VA Universities; or would we have chosen to phase them out, because we knew vets could obtain quality education through the existing public and private colleges and universities?

This Veterans Hospital must be rebuilt to deal with the unique needs of the veterans. But in our judgement, the expense of over $260,000,000 in this era of budget restraint without sufficient attention devoted to expanding veterans health benefits to allow better use of the non-Federal system is highly questionable. Isn't it time to consider a "freedom of choice" or voucher system as a practical alternative, which would use facilities more efficiently and increase the well-being of veterans through maximizing choice?

Should we perpetuate a VA system regardless of its high quality care, yet relegate vets to second class citizens because they have limited choice as to where they may go for treatment? If a vet would rather be treated in his or her own community and stay close to family and friends, should he or she be forced to travel 200 miles to receive health care?

We think the freedom of choice alternative should have been examined, particularly since we believe it would provide substantial savings, and at the same time, give veterans a choice as to where they go for medical care.

Maybe it's too late to use this more imaginative approach in Minnesota. Perhaps we have waited so long that a proper test of "freedom of choice" plan for veterans would unduly delay needed facility renovations. But we must point out in good conscience that this oversight may cost tax payers many times more than all the benefits we may derive from our many years efforts toward bed reduction in the non-Federal sector. We may have missed a major opportunity for increasing the patient's well-being, as well as, saving our taxpayers millions of dollars.

Hopefully, we will have learned something from this exercise.

It's still not too late to effectively fit the VA hospital into our total Health Care system. And while COCH has testified many times that we believe competition, if given the opportunity would function better than regulation, we feel that if any facilities are subject to certificates-of-need, all should be. The VA Hospital system should respond to the same process as our other hospitals that serve both metro and out-state patients. The VA system should also abide by the same utilization review process as do our other hospitals.

best copy available

In conclusion, our myopic community view may have prevented a once per generation chance to simultaneously decrease costs and increase health care benefits to our area's veterans. Given that mistake, we believe the VA system should subject itself to the same level of scrutiny and review as our other public and private hospitals -- namely, the certificate-of-need process. If we establish a double standard -- one in which the Federal government fosters close regulation of local facilities, but less control over its own hospital system, it will seriously undermine the credibility of the entire governmental planning process.

Testimony of

Robert Connor

Madame Chair and members of the Health Board. I address you as a private citizen and not as a member of any organization. I am a Vietnam Veteran with a service connected disability due to combat wounds. I have used the present VA facilities and feel that the VA has a dedicate staff and gives excellent treatment.

It has been five years since the United States has completely withdrawn from Vietnam but many of the casualties of that war are still alive due to advanced evacuation and lifesaving techniques used in that conflict. As the years go by they require an ever greater amount of medical attention and won't necessarily have their greatest medical needs after age 65 but could be filling VA beds in the near future.

It does concern me that your discussion concerning the VA mentions so frequently Medicare, voucher systems and treatment for veterans in community hospitals. If you disagree with the nation's policy of priorit medical treatment for veterans please come out and say it directly instea of using terms like efficient use of scarce medical resources as a smokescreen for a plan to do away with any special health care facilities for the exclusive treatment of veterans and no one else. Just because veterans will become a large percentage of those over 65 should not minimize the special status that National policy and the U.S. Congress gives them with respect to quality medical care.

The present size of the V.A. Hospital indicated a willingness to adjust the number of hospital beds needed as the veteran population's needs fluctuate. There are voluntarily less beds today than ten years ago and I want to caution you not to propose cutting the size of the facility to a point where it is too small to maintain its present level of research and education. The Minneapolis V.A. is known for its contributions to research and the number of specialists it has trained who presently serve our community.

One last point which I want to emphasize is that no GAO study attempts to consider the present global tension and when it will spark an incident of armed conflict involving this country could increase the veteran population drastically in a few short years.

Testimony of

William Meyer

WILLIAM MEYER, JR.
VETERANS SERVICE

DAKOTA COUNTY

EQUAL OPPORTUNITY EMPLOYER

ST. PAUL
MPLS.

OFFICE
830 SOUTHVIEW BLVD.
SOUTH ST. PAUL, MINN. 55075
PHONE. 612-451-1776

APRIL 29, 1980

WILLIAM A. MEYER, JR.,
DAKOTA COUNTY VETERANS SERVICES DIRECTOR

THE METROPOLITAN HEALTH BOARD HAS HAD MANY DIFFICULT TASKS THROUGHOUT THE YEARS OF ITS STUDIES, STARTING WITH THE "VIABLE TASK FORCE" IN 1976. I FEEL CERTAIN THAT YOUR DIFFICULTIES BECAME MUCH GREATER WHEN YOU MADE YOUR FIRST SUGGESTION TO REDUCE 1,500 TO 3,500 BEDS IN THE METROPOLITAN AREA BY 1983.

YOU MAY HAVE HEARD AND STUDIED, THE POINTS I WISH TO BRING FORWARD TO YOU TODAY; NEVERTHELESS, I DO BELIEVE THEY ARE WORTH REPEATING. IN THE 15 YEARS THAT I HAVE BEEN DAKOTA COUNTY SERVICE OFFICER, OUR CASE LOAD OF VETERANS SEEKING MEDICAL CARE AT V.A. HOSPITAL HAS GROWN FROM AN AVERAGE OF 9 A MONTH TO PRESENT RATE OF 99.5 PER MONTH. THESE REQUESTS WERE MAINLY FROM VETERANS LIVING IN WEST ST.PAUL (THE NORTHERN PART OF OUR AREA), TO CANNON FALLS ON THE SOUTH, FROM ELLSWORTH, WISCONSIN ON THE EAST, TO NEW MARKET ON THE WESTERN AREA, PLUS MANY MORE OF OUT-STATE AND OUT-OF STATE VETERANS WHO AT ONE TIME LIVED IN OUR AREA AND STILL USE OUR OFFICE WHEN SEEKING ASSISTANCE. THEREFORE, THE MINNEAPOLIS V.A.M.C. IS NOT ONLY A METROPOLITAN URBAN HOSPITAL, BUT IS ALSO A REGIONAL HOSPITAL, SUCH AS THE MAYO CLINIC AND HOSPITALS IN ROCHESTER, MINNESOTA.

I BELIEVE THAT THE TREMENDOUS GROWTH IN REQUESTSFOR V.A. HOSPITAL TREATMENT ARE DUE TO THE FACT THAT W.W.II VETERANS AVERAGE AGE IS NOW 61 YEARS, WITH MANY IN THEIR 70'S, AND RECEIVING SOCIAL SECURITY RETIREMENT, PLUS MEDICARE. WITH THE INCREASED COST OF MEDICAL SERVICES AND MORE AND MORE VETERANS REACHING RETIREMENT EACH YEAR, THEY MUST SEEK MEDICAL ASSISTANCE FROM THE V.A. AND/OR FROM LOCAL WELFARE AGENCIES, WHICH MANY ARE NOT ELIGIBLE FOR M.A. BECAUSE OF EQUITY IN THEIR HOMES.

AS I WAS WRITING THIS PRESENTATION, I RECEIVED A PHONE CALL FROM GRAND MEADOW, MINNESOTA AMBULANCE SERVICE, WHO WERE TO BRING TWO VETERANS TO V.A.M.C. - MINNEAPOLIS, TODAY FOR TREATMENT. ONE OF THE VETERANS MAY NEED A NURSING HOME BED, WHICH, AS YOU KNOW MINNEAPOLIS V.A. DOES NOT HAVE. GRAND MEADOW IS 100 MILES FROM MINNEAPOLIS V.A.M.C., HAVING A POPULATION OF 869. THE AMBULANCE PERSON ADVISED ME THAT THEY BRING AT LEAST ONE VETERAN A YEAR TO THE MINNEAPOLIS V.A.M.C.

TO QUOTE FROM YOUR DRAFT OF MAY 1979, "__________. THE EAST METRO TRUSTEES CONSIDERED IT UNACCEPTABLE FOR ANY PATIENT TO BE DENIED ADMISSION BECAUSE OF UNAVAILABILITY."

TO SUMMARIZE THE ABOVE:

1. THE V.A.M.C. SERVES A NEED IN A SPECIFIED LOCATION WITH A DEFINED SERVICE AREA MUCH GREATER THAN THE 7 COUNTY METRO AREA; THEREFORE, ACCESS SHOULD NOT BE CONFUSED WITH CONVENIENCE.
2. THE V.A. DOES NOT PLAN TO INCREASE THEIR HOSPITAL BEDS, BUT IN FACT PLAN TO REDUCE BEDS FROM THEIR PRESENT CAPACITY.
3. THE V.A. IS NOT PLANNING TO CONSTRUCT THE PROPOSED HOSPITAL IN A NEW LOCATION, BUT PLANS TO BUILD ON THEIR PRESENT SITE, WHICH SHOULD NOT AFFECT THE LICENSED BEDS IN THE METRO AREA.

I THANK YOU FOR GRANTING ME THE OPPORTUNITY TO MEET WITH YOU TODAY, AND I AGAIN CONGRATULATE YOU FOR THE MANY HOURS OF VOLUNTARY PLANNING YOU HAVE PUT INTO THIS STUDY.

IF YOU HAVE ANY QUESTIONS TO ASK OF ME, I WILL TRY TO PROVIDE YOU WITH THE ANSWERS.

Respectfully submitted,

William A Meyer Jr

WILLIAM A. MEYER, JR.,
DIRECTOR OF VETERANS SERVICES

WAM:sv

Testimony of

Donald Kvidt

Donald A. Kvidt
Chairman
Ramsey County United Veterans Council
1078 Van Buren St.
St. Paul, Minnesota

To: Mentropolitan Health Board

I feel that the veteran is a different class of citizen because of his service in the military and the obstacles that he encountered.

Since the Vietnam War it has been proven that the veteran could not go to a metropolitan or community hospital for examination or treatment of "Agent Orange" exposure. Today the Minneapolis Veterans Administration Medical Center is one of the leading hospitals in the study of the effects of exposure to "Agent Orange".

During the recent hearings it was noted that Vietnam might of been the last war and there wouldn't be a need of or for a veterans hospital program. It should be noted that during the past 204 years of our Republic, we have been involved in wars, police actions, internal strife and rescue missions for more than 180 years.

The Ramsey County Veterans Council believes that the proposed 725 beds and 120 acute care nursing beds are necessary of the replacement Minneapolis Veterans Administration Medical Center.

Testimony of

Marlene Nelson

I am a volunteer for the V.F.W. Ladies Auxiliary, working at the VAMC in Minneapolis. My hours are spent working on the "Gold Carpet Service," a service which was designed to meet the needs of the severely handicapped veteran patient, both out-patient and the hospital.

My area of service is the General Clinic which is housed in Buildings 5 and 6, a pretty fair distance from Building 43, for the older patient who must visit doctors in the clinics which house ear, nose, throat and eye, vascular, Neurosurgery, and proctology, just to name a few.

Having seen the same people over a period of time, you become aquainted and many times during conversation hear how circumstances have come to dictate life styles in their declining years. These people have one thing in common, very little money or none at all. Many have paid out to private nursing homes, for their care, every penny they have saved over the productive years of their life. They are now on public assistance, a very private hurt for a person with pride in his ability to care for himself financially. For these people there is no other place they can afford to go to for total health care. other than their hospital, which is the VAMC

Any casual observer can see the very strong bond which exists between the veteran patients and the V.A MC Team They are dependant on the continued support, physical and moral, of the Medical Staff in this hospital Perhaps you would understand what I am trying to say, if you could see with your own eyes, a nurse very tenderly drying with a towel, 2 feet that are black because of a circulatory disease, cutting and trimming toenails, and all the while conversing with the patient and trying to determine whether he is able to care for himself. He tells her that he is eating properly. He is able to move around enough to get some T.V. dinners into the oven once in a while. Enter the Social worker, who is, by the way, only a few doors away.

The VAMC Team is presently under one roof. It would be unfair to sever the veteran patient from his or her support system by farming them out to the community hospitals and nursing homes where they are no longer under the total care and supervision of the Veterans Hospital.

Congress has mandated that all war veterans are elegible for total health care under the Vetera Administration supervision. All that we are asking is that it remain so

Marlene Nelson
VAVS Volunteer

Testimony of

James Dustrade

PUBLIC HEARING

Metropolitan Health Board – ***Veterans Administration Hospital***, April 30, 5 p.m., Council offices. The board is holding the hearing to hear public comment on a Veterans Administration proposal to rebuild the Fort Snelling VA Hospital at an estimated cost of $221 million. Equipment costs raise the total to $264.6 million. The plan includes construction of a 725-bed acute hospital and a 120-bed nursing home.

4/30/80

To the Hearing Examiner:

I would like to add my enthusiastic support to the point of view contained in the 2/17/80 Mpls. Tribune editorial on the above subject (editorial attached).

I would also like to suggest that the Board strongly consider requesting/requiring not only that planning for the Ft. Snelling VA & the U of M hospitals be done conjointly, but that the VA planning process objectively consider & evaluate the costs/benefits of ~~an substitute site for~~ alternative sites to Fort Snelling, ones that ~~is~~ are adjacent to other hospital complexes, and specifically one in the U of M/Fairview/St. Mary's area. Considering the use of "horizontal elevators" ~~might~~ to connect to other hospitals might somewhat expand the logical search area.

I imagine that one reason the VA may not be inclined to consider alternatives to the Fort Snelling site ~~is~~ might be that they feel no other high quality, quiet, scenic sites exist. If so, I suggest Riverside Park be kept in mind, and also that the site along the Mississippi River ~~between~~ near the 35W bridge be looked

Minneapolis Tribune

Established 1867

Charles W. Bailey Editor
Wallace Allen Associate Editor
Frank Wright Managing Editor
Leonard Inskip Editorial Editor

Donald R. Dwight Publisher

20A

Sunday, February 17, 1980

Separate new VA hospital is wasteful

The American public is growing increasingly disenchanted with the performance of the federal government, according to consistent findings of opinion polls. Much of the blame goes to unresponsive programs, to remote, single-purpose bureaucracies and to Congress's habit of assuming that federal largess automatically solves problems.

Minnesota is about to witness a classic example of what bothers people. An oversized and expensive new federal installation apparently will be designed with little attention to community planning or to avoiding a costly duplication of facilities. Once built, it will be unnecessarily costly to operate.

The project is a $220-million Veterans Administration Hospital in the Twin Cities. Although President Carter's 1981 budget contains $15 million to plan the hospital, the administration apparently has already made two vital decisions: The hospital will be a separate, independent unit, and it will be located at Fort Snelling, site of the present VA hospital.

Never mind that the University of Minnesota also proposes to replace its equally old hospital at a cost of at least $220 million; that planning and building part or all of the new VA hospital jointly with the university would offer important savings; that joint operation was proposed in 1970 by the university medical school; that both hospitals engage in teaching and research, as well as patient-care. And never mind that most VA hospital doctors have joint appointments at the university.

The project is not subject to approval by the Metropolitan Health Board or Metropolitan Council, even though a federal cost-containment law requires that they approve all other metropolitan-area hospital construction. Apparently Congress and the Carter administration find that containing community hospital costs is desirable, but containing federal hospital costs is not.

The Carter proposal is for 845 beds, 100 more than the VA hospital now operates, even though the hospital now is only 78-percent occupied. Further, under federal law, the Metropolitan Health Board and the other Twin Cities-area hospitals, whose occupancy rates are just below 75 percent, are working to close about 1,000 excess beds — and those hospitals next must trim duplicate services and even more beds.

Veterans have a legal right to *free* medical care, and the country long ago chose — for better or worse — to provide this care in a separate hospital system. The old Fort Snelling facilities are outmoded; a 1978 study found only two other veterans' hospitals in worse physical shape.

But none of that means a veterans hospital should or must be planned, built and operated independently. Nor does it mean a new veterans hospital should have 200 or 300 beds more than needed. And it does not mean that equal, or better, care could not be provided veterans if a new VA hospital shared facilities with a new university hospital. Just one example: If all surgical units from both hospitals were combined at the university, the duplication of about 200 beds and other expensive equipment and services would be avoided.

Building two large and entirely separate hospitals in the Twin Cities at a cost of nearly a half-billion dollars is plainly not justified — especially when health-care costs are soaring, and the president cannot deliver on his pledge to balance the federal budget. But the capital costs, though large, should be less alarming to taxpayers than the prospects for ongoing operating costs; hospital operating budgets over two years usually equal the original capital costs.

Vice-President Mondale apparently was instrumental in getting the Carter administration to approve a new Fort Snelling hospital. And Rep. Martin Sabo, whose district includes the Fort Snelling area, sits on the House appropriations subcommittee that will handle the hospital. Sabo, to his credit, suggests that the two projects should be planned cooperatively. But suggestion alone won't get the job done. Mondale and Sabo should team up in the public interest and support a joint-planning and facility-sharing *requirement* in the appropriations bill.

Exhibit VII

Copies of Letters Received

by the Metropolitan Health Board

Letters in support of the VA project have been received by the Health Board from:

1. Albert Quie, Governor, State of Minnesota
2. James Swanson, State Representative, District 37B
3. Minnesota Association of County Veterans Services Officers
4. Gene Elston
5. LeRoy Gutzmer, Veterans Service Officer
6. Mr. and Mrs. Richad Pichner, Owatonna, MN
7. Jackie Schwartz, Legislative Chairman, VFW Auxiliary 4046
8. Elma Gogman, Secreatry, VFW Auxiliary 494
9. Dorothy Blakesley, Aitkin, MN
10. Herbert Nutter, Stewart, MN
11. Herman G. Karlsgodt, Post Commander, American Legion Post 622
12. Hiram Fuller, Legislative Chairman, DAV
13. John Tonneson, Commander, DAV Minneapolis Chapter No. 1
14. Dean Schumaker, Commander, American Legion Post 385
15. Blanche Coppa, Bayport, MN
16. Rolf Olson, Minneapolis, MN
17. Rick Barnett, State Commander, Wisconsin American Legion
18. Roy Berg, American Legion, Post 71
19. Truman Benson, Commander, New Ulm Chapter, DAV

Letters not supporting (though not necessarily opposing) the project:

20. G. Rappaport, Chairman of the Board, Mt. Sinai Hospital, Minneapolis

Letters supporting Health Board position:

21. Gerald J. Wantulok, Executive Director, Central Minnesota Health Systems Agency, Sauk Rapids, MN

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
ST. PAUL 55155

ALBERT H. QUIE
GOVERNOR

April 30, 1980

The Honorable Dave Durenberger
Member of Congress
353 Russell Senate Office Bldg.
Washington, D.C. 20510

Dear Dave:

This is to inform you of my support for construction of a new V.A. hospital to replace the existing hospital in Minneapolis. It is my understanding that the Veterans Administration has conducted extensive reviews of various proposals for upgrading the medical facility - and has concluded that the construction of a new facility is in the best interests of the federal government.

As you are probably aware, the Minneapolis V.A. Hospital currently ranks as one of the top V.A. hospitals in the nation in education and training as well as research programs. It has been estimated that over one-half of the physicians who receive their training at the Minneapolis V.A.M.C. remain in Minnesota to practice medicine. Thus, the V.A.M.C. stands as a resource to the State of Minnesota as well as a much needed medical facility for the veterans of the upper midwest.

For these reasons, I strongly support construction of a replacement facility at this time. Any delay in this program could have a detrimental effect on this project. Recently, the House Committee on Veterans Affairs notified the Speaker of the House that it approves the V.A.'s construction plans. Your support of this project throughout the appropriations process would be much appreciated.

Best wishes.

Sincerely,

ALBERT H. QUIE
GOVERNOR

AHQ:vrl

James C. Swanson
District 37B
Hennepin County
Committees:
Health and Welfare, Chairman
Appropriations
Division on Education
Financial Institutions and Insurance
Rules and Legislative Administration

Minnesota House of Representatives
Martin Olav Sabo, Speaker

RECEIVED
HEALTH BOARD
St. Paul, Minn.

April 30, 1980

Coral Hoyle, Chair
Metro Health Board
Metro Square Building
St. Paul, Minnesota

Dear Ms. Hoyle:

I would like to take this opportunity to express my support for the proposal to replace the Veterans Administration Hospital at Fort Snelling.

As I am certain you know, the proposed hospital on the present site of the VA complex at Fort Snelling has the strong support of Minnesota's veterans organizations. Since they are the people the new hospital will serve, it is my hope that you will give their viewpoint ample consideration.

The present VA hospital is clearly outdated, not only in terms of its ability to serve our growing and aging veteran population, but also, because of current fire and safety code deficiencies which exist. As you review the current VA proposal, please keep in mind that the new medical facility is regional in nature and therefore serves a larger geographical area than just Minneapolis and St. Paul. Also, you should keep in mind the high utilization rate for the present hospital. It is my understanding that it has one of the highest hospital occupancy rates in the Twin Cities.

Finally, I am concerned over the recommendation that the VA hospital share certain facilities and programs with the University of Minnesota. I view this as another example of the inner city hospitals consolidating their efforts in or near downtown Minneapolis. Instead, it may make more sense to decentralize some of these inner city high cost programs.

In closing, please keep in mind your decision could mean that some veterans may be denied care with the VA system because

Reply to ☐ 372 State Office Building, St. Paul, Minnesota 55155

beds would not be available. As Chairman of the House Committee on Health and Welfare, and as a legislator whose district includes the VA hospital, I have seen the outstanding services provided by the current facility to our veterans. I hope you will join me in supporting the VA proposal so that we may continue that commitment to our veterans.

Thank you for your consideration of this matter.

Sincerely yours,

James C. Swanson

James C. Swanson
State Representative
District 37B

pwk

MINNESOTA ASSO CO VETS SVC SCHUL
COURT HOUSE
BRAINERD MN 56401

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2188294066 MGM TDBN BRAINERD MN 203 04-29 0320P EST

METROPOLITAN HEALTH BOARD
METRO SQ BLDG 7TH & ROBERT ST
ST PAUL MN 55101

R... ED
HEALTH BOARD
St. Paul, Minn.

ATTENTION CHAIR PERSON OF THE BOARD:

WE AS A GROUP OF VETERANS SERVICE OFFICERS EMPHATICALLY OPPOSE ANY CUTS OF THE ORIGINAL PROPOSAL FOR THE NEW VA HOSPITAL IN MINNEAPOLIS.

THE NUMBER OF BEDS AVAILABLE NOW IS INSUFFICIENT TO HANDLE THE GROWING NUMBER OF VETERANS NEEDING MEDICAL ATTENTION DUE TO ADVANCING AGE AND ITS ASSOCIATED MEDICAL PROBLEMS.

WE FEEL THAT THE METROPOLITAN,HEALTH BOARD IS TAKING TOO MUCH CONSIDERATION IN THE AMOUNT OF MONEY THE CIVILIAN HOSPITALS AND NURSING HOMES MAY LOSE, NOT FOR THE MEDICAL HEALTH AND CARE LAWFULLY DUE THE VETERANS OF OUR COUNTRY, FOR WHICH OUR ASSOCIATION SERVES.

I WISH TO POINT OUT THAT THE MAJORITY OF THE VETERANS DO NOT HAVE MEDICAL INSURANCE TO PAY FOR THE CARE THEY ARE RECEIVING AT THE VA HOSPITAL, AND IF SENT TO CIVILIAN HOSPITALS, FOR LACK OF BED SPACE, ADD A BURDEN TO THE ALREADY BULGING WELFARE ROLLS, OR WILL NOT SEEK TREATMENT BECAUSE OF THEIR PRIDE, WHICH IS THEN THE DETRIMENT TO THEMSELVES.

WE THE ASSOCIATION THEREFORE SUPPORT A TOTAL 845 BED PROPOSAL TO INCLUDE NURSING CARE BEDS.
ROBERT M ANDERSON, PRESIDENT MINNESOTA ASSOCIATION COUNTY VETERAN SERVICE OFFICERS

15:21 EST

MGMCOMP MGM

April 28, 1980

Chairperson Coral Houle
Metropolitan Health Board
300 Metro Square Bldg.
St. Paul, Mn. 55101

Dear Ladies and Gentlemen of the Board;

Permit me to pass along my thoughts regarding the Fort Snelling Veterans Administration Hospital. Two points should be mentioned first. I am presently on 100% Social Security Disability due to four prior heart attacks and advanced emphysema at age sixty three. Secondly, I was discharged Wednesday April 23rd from the Fort Snelling VA Hospital for treatment for my fifth heart attack.

During the period of my hospitalization and treatment, I was able to talk with other patients in my ward who were drawn to the Fort Snelling facility from such areas as the Upper Peninsula of Michigan, Solon Springs and LaCrosse, Wis., Warroad, Worthington and Bemidji, Minnesota, Mason City and Spencer, Iowa as well as others from the Twin Cities area and central Minnesota.

These were men who needed the expertise that was available at the V.A. hospital but was not available in their immediate home towns. In one case, the patient from Bemidji had received a bill for $3,750 for four days treatment and nothing had been determined nor had his discomfort been relieved. In nine of the patients conditions with whom I talked, seven had no hospitalization because they, like myself are uninsurable. I won't be eligible for Medicare until Oct. 1981.

The primary point I would make is that the Fort Snelling V.A. facility serves parts of Wyoming, both Dakotas, Wisconsin, part of Illinois, Iowa and part of the Upper Peninsula of Michigan. The medical research and skill needed in every case was not available for certain specific illnesses in the areas mentioned but is available at Fort Snelling. The excellent staff of doctors, nurses and nurses aides are augmented by the volunteer help from men and women (all veterans or wives of veterans) from various organizations such as the VFW, DAV, American Legion and other service groups who would find it virtually impossible to assist as they do if the VA facility were moved or combined with a non-veteran care center.

A further point should be considered. It has been said that the Twin Cities is over-built in terms of hospitals and bed space. I suggest that a map be examined and the exact location of each hospital in Minneapolis and St. Paul be pinpointed to determine how close each facility is to another. I offer two cases in point. One, Eitel hospital and Metropolitan Medical Center in Minneapolis. Two. St. Johns and Mounds Park hospitals in St. Paul. In both cases, these are hospitals built within two miles of each other. A sidelight, potential patients south of the Minnesota river must travel many miles for proper medical care often in an emergancy in heavy traffic.

I submit that if there is a surplus of facilities and beds in the Twin Cities, before you penalize the veterans of every war or "police action" since World War I, you consider the following options.

Close Eitel and any other older facility as a hospital, demolish and sell the land to developers to restore the land to a higher tax productive status. Or, convert these same facilities into nursing or health care centers for the elderly men and women of all races. A third option would be to sell to private developers who would commit the properties to be converted into low income housing units for the elderly under H.U.D. participation. Such a shortage of housing definitely does exist!

Before you make a final decision, if you haven't already done so, please take an unannounced tour through the halls, the wards, the various intensive care facilities and I guarantee you will come out with a new and greater appreciation of how the Veterans Administration gets the most out of the dollars allocated.

Please accept these thoughts as constructive and hopefully helpful rather than critical.

Sincerely

Gene G. Elston

4211 Oregon Ave. N. Apt. 702
New Hope, Mn. 55428

cc/ Sen. Rudy Boschwitz
Sen. David Durenberger
Rep. Martin Sabo
Rep. Bill Frenzel
Vice Pres. Walter Mondale

SCOTT COUNTY COURT HOUSE - SHAKOPEE, MINN. 55379 PHONE (612) 445-7750 EXT 179

April 24, 1980

Ms. Betty Pink
Metro Health Board
Metro Square Bldg.
7th & Robert St.
St. Paul, MN. 55101

Dear Ms. Pink:

I, LeRoy Gutzmer, Veterans Service Officer of Scott County, believe that we need the 750 bed new hospital construction and 120 skilled nursing beds planned by the Veterans Administration.

The present structure is so outmoded any patient with any disabilities cannot get to and from all the clinics by himself. It is approximately one mile from the entrance in building 43 (the main building) to building 7 (the last building of the clinics). Sometimes it is necessary to go to a clinic in the out buildings, go to 43 for x-rays and tests, and return to the clinic, for a total distance of two miles. With a new building, these old buildings would all be torn down and clinics would all be within easy reach of an elevator.

It is estimated to renovate even the newest building (43) and the other buildings to bring them up to code, would cost one hundred million dollars. We would still have the old set-up, inconvenient as it is.

I also contend about 90% of the veterans who go to the VA Hospital would never use a hospital in the Metro area. They would use their local community hospital or some other major hospital as Mankato or Rochester.

The VA Hospital has to be left in its present location because of its easy accessibility. It is much easier to reach than any other hospital in the metro area, from all points it serves. There is adequate parking and beautiful surroundings for visitors and patients who are able to leave their beds.

I believe this money that is earmarked for our area VA Hospital will help our community with jobs during construction and, of course, after completion. If we do not accept it at the present time, we can definitely look for closing of the major part of the medical center by the year 2000.

I strongly urge you to provide support for the 725 bed hospital and 120 bed nursing care facility, known as the VA Medical Center, Minneapolis.

Sincerely,

LeRoy Gutzmer

LeRoy Gutzmer
Veterans Service Officer

VETERANS SERVICE OFFICE
LEROY GUTZMER/SERVICE OFFICER

Scott County Is An Equal Opportunity Employer

RECEIVED
METRO COUNCIL
St. Paul, Minn.

Metropolitan Council
Metro Square Bldg
St. Paul, Mn 55101

We wish to express our concern about your adverse outlook on building a replacement building for the Mpls VA Hospital.

First of all the Metro Health Board and the Counsel of Community Hospital has no business making any kind of a decision on a Federal funded institution and should have told the Carter Administration so.

The Mpls VA Hospital is not just a Metro hospital. It serves a large portion of veterans thoughout the upper Midwest. Many Veterans from our own area have looked for help from the Mpls VA. It works with the Mayo Clinic as well as other hospitals as a teaching hospital. The research done there would be a lost to great to even measure.

The new replacement center would not be adding new beds but we do need a up dated facility. This new REGIONAL facility must be built.

Shirley & Richard Fichner

Mr. & Mrs. Richard Fichner
1071 So. Oak
Owatonna, Mn 55060

VETERANS OF FOREIGN WARS AUX. #4046
Shakopee, Minnesota

April 23, 1980

Mrs. Betty Pink
Metro Health Board
610 McDevitt
Shakopee, MN. 55379

Dear Mrs. Pink:

I am writing to you as legislative chairman of the Veterans of Foreign Wars Ladies Aux. #4046, Shakopee, MN. Our Auxiliary urges your support of the proposed new Veterans Hospital in Minneapolis. As members of the Auxiliary, we know what a benefit such a facility would be to the veterans in our area.

The present hospital is in a sad state and often times is inconvenient for the disabled veteran and also the elderly veterans. They never know what building they have tc report to for their particular clinic. Upon our visits to the hospital, the 16 man wards leave something to be desired. The veteran we happened to visit with was in fairly good health, while the veteran in the next bed to him was terribly ill. One of our visits to the hospital was during the hot summer months. We would sure hate to be patients there at that time of the year without any air conditioning.

As far as location of the hospital, we feel the present location is great. There is no need for patients or visitors to bother with downtown traffic; and parking space is ample.

It makes much more sense to us to build a new facility than to renovate the old building at a cost of one hundred million dollars and still have an old building.

As I stated earlier, the Veterans Hospital is and will remain a valuable benefit to our veterans, who otherwise may not be able to afford the medical care they are now receiving.

We would appreciate your support of the new Veterans Hospital!

Sincerely,

Jackie Schwartz

Jackie Schwartz
Legislative Chairman
2024 Eagle Creek Blvd.
Shakopee, MN. 55379

Aitkin, Minnesota
April 20, 1980

Member - Metropolitan Health Board

We, of the American Legion Auxiliary believe the new VA Medical Center at Fort Snelling REPLACEMENT facility should be built at the same site as the outmoded existing hospital.

This facility serves a 7 - state area - not just the Metropolitan area - therefore it should be located at the best possible place to serve the majority and not a select few.

The attitude adopted by the Metropolitan Health Board and the Twin City Area Hospital Associations, that they should have the Final Say is all wrong. They fail to recognize that the community they serve as a planning board and the communities served by this Medical Facility are two vastly different areas.

Please give this matter your careful consideration.

"TOGETHER — WE HELP AMERICA WORK!"
"TOGETHER — WE CAN PRESERVE OUR VA MEDICAL SYSTEM."

Thank You,
Mrs. Leo J. (Dorothy) Blakesley
Past Auxiliary President

Little Pine Rte. Box 220
Aitkin, Mn. 56431

I was appointed by the Stewart Legion Post #185 to write to you about the planned new V.A. Medical Center at Fort Snelling.

Our Post strongly supports your efforts ~~to~~ to obtain the replacement facility. We sincerely hope completion of the facility will be done as soon as possible.

Thank you for being able to be of assistance like this.

Legion Member
Herbert V. Nutter
Stewart, Minn

ST. FRANCIS AMERICAN LEGION
POST NO. 622
ST. FRANCIS, MINNESOTA 55070

April 24, 1980

Mr. Daniel Cooney
V.A. Hospital
Minneapolis, MN 55417

Dear Mr. Cooney:

The St. Francis American Legion Post No. 622 would like to give our wholehearted support to the plans of the Veterans Administration to construct a new replacement VA Medical Center at Fort Snelling.

We most certainly feel this is a much needed facility for our veterans in the areas this center will cover.

Sincerely,

ST. FRANCIS AMERICAN LEGION
POST NO. 622

Herman G. Karlsgodt

Herman G. Karlsgodt
Post Commander

HGK:wt

STATEMENT OF
HIRAM J. FULLER
LEGISLATIVE CHAIRMAN
DISABLED AMERICAN VETERANS
TO THE
METROPOLITAN HEALTH BOARD
APRIL 30, 1980

PROPOSED REPLACEMENT VETERANS ADMINISTRATION MEDICAL CENTER

Mr. Chairman and Members of the Metropolitan Health Board:

The more than 10,500 members of the Disabled American Veterans in the State of Minnesota who are the prime veteran consumers of V. A. Medical Facilities, strongly support the replacement Veterans Administration Medical Center at the Fort Snelling site.

The Disabled American Veterans Organization, chartered by Congress in 1932 to be the spokesman for the wars' disabled, wish to make it clear at the start that the V. A. Medical Center serves the veteran consumer living in a seven state area and to remind this committee that you serve as a planning board for a seven county area only. We resent and will vigorously oppose any attempt to impose your judgement on the vastly larger area served by the V. A. Medical Center.

There is no question that a replacement is necessary when one considers that six of the buildings are of outmoded 1926 vintage with the newest being built in 1953 with 1947 plans. Despite the fact the Outpatient Clinic is in an old Fort building, built in the 1800's, over 200,000 service connected veterans are served at this facility.

The Veterans Administration Medical Facilities are for the veteran consumer only, and only the veteran population numbering 340,000 in the primary area served by this facility need be considered in plans for the bed capacity of the new facility. The referrals from the seven state area can be expected to increase with the proposed new facilities latest equipment and medical skills.

The present facility operating short of bed capacity is due to a curtailment in personnel and equipment, and not due to a lack of use demand. Your efforts should be focused on assisting the Veterans Administration obtaining adequate personnel for its needs to provide the best in medical care.

The present spacious 111 acre site is the most ideal and logical location for the replacement facility. Major highways are easily accessible; it is near the airport; it is within walking distance of the V. A. Center in the Federal Building where patients records are located for easy access and use by the hospital and outpatient clinic and for the veteran consumer to avail himself of all V. A. services. The present location affords ample parking for patients, V. A. personnel, visitors and volunteer workers whose services are so vital to the patients morale, an important part of the treatment program.

The V. A. Medical Center has one of the largest and most extensive research service centers in the Veterans Administration and is vital to medical training with over 1800 trainees in its various departments. Over half the doctors who receive their training at the V. A. Medical Center remain in Minnesota.

We strongly oppose those who would have any new V. A. facility as a part of, or considered with, any new medical facility at the University of Minnesota where space is already crowded, and at a premium for building; parking facilities are practically extinct; access is over congested highways and streets; ambulance routes through heavy traffic; the airport is far removed; and most important the veteran's records would be exposed to non-veteran personnel, a violation of Federal law and regulations.

We strongly oppose those who would have veterans receive hospital and medical treatment in the private sector of the Metropolitan area or any private hospital at V. A. expense, not only because it would be most impractical and impossible to administrate, but the costs of V. A. medical are 15% lower than in the private sector. Again you cannot place the veteran's records in the hands of non-V.A. personnel. Veterans' records would be scattered over a wide area, become lost and unavailable to the V. A. when needed.

It appears that the V. A. is being made the scapegoat for the empty beds in the private sector which is not the fault of the V. A. but the fault of blunders in planning and estimating bed needs in the private sector, and now trying to fill those beds with veterans.

In short, the Disabled American Veterans wholeheartedly supports the building of a replacement Medical Center on the site of the present medical facilities as outlined in the plans without further ado as it is our contention that the many advantages far outweigh the paucity of any advantage, if any, to build elsewhere or reduce its size. The Veterans of this State deserve no less.

Daniel Cooney
VA Hospital
Mpls., Mn. 55417

April 28, 1980

Dear Mr. Cooney,

The following is a letter which I had written previously in response to an editorial appearing in the Minneapolis Sunday Tribune. I had refrained from sending it, how in deference to our adjutant who had since then sent to the same paper a letter which was shorter and more objective. My letter reads as follows:

Just finished reading your editorial entitled "Separate VA Hospital is Wasteful," and I disagree with you. A new Veterans' Administration Hospital is sorely needed, and it belongs at its present location.

It may be true that a transfer of the VA facility to the University of Minnesota Campus would accomodate the staff of the university; but it would not, on the other hand, serve the best interests of the Veteran for various reasons. Among other things a move of this nature would, for maximum efficiency of operation of the facility to obtain, necessitate a consolidation of administrative and professional staffs; and these, in the final analysis, would unquestionably have to be university personnel. If the VA and the University collided in one complex, the result might be catastrophic. In any event I am certain that it would be illegal for the University to run the Veterans' Hospital; in other words, special legislation would have to be enacted in order for it to do so

Furthermore, I am certain that the [illegible] not want to run the Veteran's Hospital because University personnel already have their hands full just properly running their own hospital, in caring for their patients, in conducting research, and in training their students.

Your point that the veteran is entitled to professional service and to benefits is, of course, well taken if only for the reason that many veterans originally incurred their disabilities in physically hellish situations which have existed from time to time during the several armed conflicts in which our nation has been involved. These people answered their Country's call at those times and performed their tasks admirably. Many problems directly related to those situations continually exist and presently require the services of professionals and others who have the uniquely developed insights and the expertise to deal with them. The veteran's well being is thus dependent on (a function of) everyone's understanding of individual and collective veteran problems. By and large, this is accomplished only within the medium of a veteran's hospital.

The new veterans hospital must be built at its present location, the prevailing philosophy and atmosphere must be the established, traditional ones, and the care and treatment given to the patients must be optimally excellent.

In addition, please be familiar with one of the most serious problems facing America today. Delayed Stress Reaction or Post-Vietnam syndrome was identified as the result of an elaborate study conducted.

for the Disabled American Veterans, the "Forgotten Warrior" research project, at Cleveland State University. Because of the seriousness of this matter, the Disabled American Veterans organization is currently sponsoring a program termed the "Outreach Program", through which our National Service Officers and others try their utmost to deal with it. The solemn affirmation of the Marines that they never leave their casualties behind seems to apply to this and to the other situations to which I have referred in this letter.

Veteran's affairs are of the highest priority and must never be, in any manner, or degree, subordinated to motives or purposes of a lesser nature. And since these seem to be in jeopardy it would, furthermore, suggest that in terms of moral quality and collective purpose our great nation is declining. It suggests that we are riding for a fall, and that we had better get it all together or somebody is going to knock our blocks off.

Sincerely,
John R. Tonneson
Commander,
Disabled American Veterans,
Mpls. Chapter #I

American Legion Post # 385
Wanda, Minnesota 56294
April 21, 1980

Metropolitan Health Board
Review Committee
V. A. Medical Center
Minneapolis, Minnesota

Committe Member:

Re: V. A. Medical Center

Please be advised that the members of Post # 385 Wanda, Minnesota would like to go on record as being in favor of this new center.

These men gave up a lot to help fight our Wars and it is no more then right that we should want to give them the best in medical attention and facilities.

We would appreciate your support in this endeavor.

Yours truly,

Dean Schumacher

Dean Schumacher, Commander

225 N 3rd St.
Bayport, Mn.

Dear Mr Cooney

Your help is urgently needed immediately to keep the VA Medical Center at Fort Snelling. VA plans call for a replacement facility to be built at the same site as the present outmoded inadequate hospital currently serving veterans in a wide, all geographic area. which covers All of Minnesota and neighboring states, as well as Wyoming, Montana and Nebraska for certain sophisticated medical procedures.

Currently, these plans are being reviewed by you of the Metropolitan Health Board.

I feel that the community you serve as a planning body, and the communities served by this Medical facility -- are two vastly different areas. I also feel that this facility should remain where it is now located, [illegible] the replacement of new building.

Would you please use your influence to help keep the V.A. Medical Center located at its present site, at Fort Snelling? We need this facility now, as the Veterans of World War Two are at the age where it will be greatly needed.

I sincerely hope you will consider helping us.

Yours truly

Blanche Coppa

April 24, 1980

Mr. Daniel Cooney
Veterans Administration Medical Center
Minneapolis, Minnesota 55417

Dear Mr. Cooney:

I am writing you concerning the hearings being held on the proposed new Veterans Administration Hospital to be built at the site of the present hospital. The proposal to combine the VA and the University Hospitals is, in my opinion, ridiculous. Water and gasoline don't mix and neither does a state and federal operated project. Each has its priorities and will not give in to the other without a struggle.

The proposal to reduce the number of beds makes sense if the VA is going to continue its refusal to admit patients. Many patients are now being told to go to their own doctors due to the fact that there is a lack of bed space and not enough help to take care of the patients that are admitted. A strong VA Hospital program is necessary for this area.

The reducing or closing of the hospital would be a jolt on the economic factor in this area. The transfer to the University Campus would create a difficult problem for the patients. The lack of parking would reduce family visits, volunteer work and outpatient treatment which would be to the detriment of the patients for whom the care was originally intended.

Consider the time and money that volunteer's and organizations contribute to the VA hospital and add that to the cost of operating a joint venture and you will find that it becomes a mighty expensive operation.

Sincerely yours,

Rolf Olsen

Rolf Olsen
5748 16th Avenue South
Minneapolis, Minnesota 55417

WISCONSIN AMERICAN LEGION

OFFICE OF STATE COMMANDER

STATE HEADQUARTERS
[illegible] EAST STATE [illegible]
MILWAUKEE, WISCONSIN [illegible]

April 23, 1986

Daniel Cooney
V. A. Hospital
Minneapolis, MN 55417

Dear Mr. Cooney:

The Wisconsin American Legion is deeply concerned about the planning for the new V. A. Medical Center to be built in Minneapolis that will replace the V. A. Medical Center at Fort Snelling. The present V.A.M.C. has throughout its years had a grand history of serving not only the veterans in Minnesota but the veterans in surrounding states, including western Wisconsin.

Wisconsin veterans are concerned that recommendations to the V. A. by the Metropolitan Health Board on plans for the new Medical Center will be based on local community need and will not encompass the needs of the entire area to be serviced by the new facility.

I had the opportunity to visit the V.A. Medical Center at Fort Snelling this year in my tour of V.A. Medical Centers in Wisconsin, Minnesota and upper Michigan. I observed first hand that many Wisconsin veterans require care at the Minneapolis facility.

Wisconsin veterans and veterans of the entire region served by the new facility must not be deprived of adequate care or admission because they don't live in Minneapolis and have been overlooked in the planning for the new V.A.M.C. I urge you to give equal consideration in your recommendations to all veterans who reside within the region to be served by the new Center.

Sincerely yours,

Rick Barnett

RICK BARNETT
State Commander

RB:bo

WEST DULUTH POST NO. 71
AMERICAN LEGION
5814 GRAND AVE.
DULUTH, MINNESOTA 55807

April 26, 1980

Dear Congressman

Our post urges total support to the plans of the Veterans Administration Medical Center Replacement facility at Ft. Snelling.

We also urge you to recommend the following of the Veterans organizations construction schedules.

Our post also requests that other groups in the seven state area be able to have input into the final say of this project, not just the Twin City Hospital Associations.

Sincerely,
Roy A. Berg
Roy A Berg Adj.

DISABLED AMERICAN VETERANS

NEW ULM CHAPTER NO. 15
NEW ULM, MINNESOTA 56073

April, 25th. 1980

To: The Health Board of the Metropolitan Council

We, the Disabled American Veterans, Chapter #15 of the New Ulm, Minnesota area, urge you to keep the Veterans Medical Center at Fort Snelling.

We have the acreage and it is easily accessable to the main highways. Veterans have a hard time getting around, so please keep things as they are.

We do need the replacement facility. Thank you for your interest.

Very truly yours,

Truman A. Benson, Comm.

Mount Sinai Hospital
2215 Park Avenue
Minneapolis, Minnesota 55404
(612) 871-3700

April 9, 1980

Ms. Coral Houle
Chairperson
Metropolitan Health Board
300 Metro Square Building
St. Paul, Minnesota 55101

RE: Veteran's Hospital/Nursing Home Proposal

Dear Ms. Houle:

In response to your request for local institutions to comment upon the proposed replacement of the Veteran's Administration Hospital, the Mount Sinai Hospital Board of Governors has held lengthy discussions. This letter is written to convey that position.

Mount Sinai Hospital expresses grave concern that the Federal Government is being inconsistent. While applying pressure to the private hospital system, the result of which would be to reduce the number of hospitals and facilities in the Twin Cities metropolitan area, it is also promoting replacement of a very large facility, which is totally within its control. It is curious to note further that the most generous estimate of what might be saved through the closure of whole hospitals, as proposed by the Metropolitan Health Board, is approximately 1/10th of the cost proposed for the new VA Hospital.

Therefore, at a time when the Federal Government is presumably taking the lead in balancing its budget, Mount Sinai Hospital strongly urges that the Veteran's Administration should make every effort to contract with private facilities, which admittedly have some excess capacity, for the care of our veterans.

We recognize that the Metropolitan Health Board does not have other than advisory authority in this review. We, therefore,. urge you to incorporate our position in your recommendations to Washington. We should also like to congratulate members of the Health Board for taking the initiative in urging that the Veteran's Administration proposal be subject to the same type of review as are proposals of other hospitals in the community.

We appreciate the opportunity to convey our position to members of the Health Board.

Sincerely yours,

Gary B Rappaport

Gary B. Rappaport
Chairman of the Board
jr

BENTON
CASS
CHISAGO
CROW WING
ISANTI
KANABEC
MILLE LACS
MORRISON
PINE
SHERBURNE
STEARNS
TODD
WADENA
WRIGHT

CMHSA

CENTRAL MINNESOTA HEALTH SYSTEMS AGENCY

113 Division Street, Sauk Rapids, Minnesota 56379
(612) 253-2930

April 30, 1980

John Hurley
Metro Health Board
300 Metro Square Building
7th and Robert Streets
St. Paul, Minnesota 55101

Dear John:

The Board of Directors of the Central Minnesota Health Systems Agency at their April 24, 1980 Board of Directors meeting heartily endorsed the recommendations of the Metro Health Board Staff concerning the Minneapolis Veterans Administration project.

Sincerely,

Gerald J Wantulok

Gerald J. Wantulok
Executive Director

GJW:cls

APPENDIX B

Citizens League,
Minneapolis, Minn., April 4, 1980.

Senate Committee on Veterans' Affairs,
Russell Senate Office Building,
Washington, D.C.

Attention: Janice Orr.

I thought it might be helpful to those of you in Washington, involved in the decision about the proposed Veterans Administration replacement hospital in Minneapolis, to be familiar with the experience here, ten years ago, with the replacement of the (Hennepin) county public hospital. That experience is still very much on the minds of those involved, here.

Hennepin County General Hospital was then, as it remains, an important institution. It was an important part of Hennepin County government. It played an important part in the teaching system, in this region. It provided important service to a particular population. It had operated for years in an obsolete and inadequate building. It needed replacement. In 1969 the money became available. And the planning for the new facility began.

Hennepin County ended by building a hospital with fewer beds than were first proposed; and by building what became "Hennepin County Medical Center" not as a free-standing institution (again, as first proposed) but as a part of a joint development with a community hospital in the area.

Obviously, something occurred during the planning and discussion about the new hospital that led to a fundamental change in the original intention. It was simply this: a realization that a significant part of the institution's traditional clientele had been the "indigent" patient. And that the future could not be planned on the assumption of the continuing existence of "medical indigency." The spread of private insurance, and the prospect of universal public insurance, simply had to be factored-in. It was. And when it was, it led to a decision that—with the distinction between the county hospital and the community hospital system likely to be blurring-out, over the coming years—there had to be a closer relationship between the two, both in planning and in development. You can see that relationship today, in the physical linkage of HCMC and Metropolitan Medical Center, over Chicago Avenue, in downtown Minneapolis.

This may be relevant to the situation involving the VA hospital here, to the extent that its admissions and patient-days also include any significant proportion of veterans admitted on "pauper's statements." You will know, or will be able to learn, much better than we just what this proportion is. To the extent it is, in fact, a significant proportion, the VA may want to consider as Hennepin County did—a closer relationship with the community hospital system, and with its planning.

It is important the point of view from which we all approach this.

Our own approach would not be to try to involve the community further in the planning of the VA hospital here. Rather, it would be to hope that the VA will want to involve itself further in the planning of the community hospital system, in its own interest. It is this community hospital system which cares for the majority of individuals who are veterans. With the extensions of third-party insurance, this role would only enlarge. It is the community health-care system, too, which the VA itself uses, at times, through "VA contracts" and "fee-basis care." A substantial expansion of this concept of a de-centralized "VA hospital," linking into all the hospitals of the community and resting on the principle of free choice of vendor, might be attractive both for the VA and for the veterans, as individuals.

Sincerely,

Ted Kolderie,
Executive Director.

NATIONAL LEGISLATIVE COMMISSION,
April 9, 1980.

Hon. ALAN CRANSTON,
Chairman, Senate Committee on Veterans Affairs, Russell Senate Office Building, Washington, D.C.

DEAR CHAIRMAN CRANSTON: The enclosed visitation report is being submitted in compliance with your staff's request of April 8 during the meeting on the Minneapolis VA hospital replacement.

This is our most recent evaluation of the existing hospital and we trust that it is of some assistance to you.

Sincerely,

MYLIO S. KRAJA, *Director.*

Enclosure.

No. 9-040

NATIONAL VETERANS AFFAIRS AND
REHABILITATION COMMISSION
THE AMERICAN LEGION
VISITATION REPORT
OF
VETERANS ADMINISTRATION MEDICAL CENTER
MINNEAPOLIS, MINNESOTA
AUGUST 6-17, 1979

Date Received: August 27, 1979
Type of Medical Center: General Medical and Surgical

WALDON L. LYNCH
National Field Representative
The American Legion
1608 K Street, N. W.
Washington, D. C. 20006

VETERANS ADMINISTRATION MEDICAL CENTER
MINNEAPOLIS, MINNESOTA

I. INTRODUCTION

A regularly scheduled visit to the VA Medical Center, Minneapolis, Minnesota was conducted during the period of August 6-17, 1979. The purpose of this visit was to determine the timely quality and quantity of patient care presently given to veteran patients.

MISSION OF MEDICAL CENTER

The mission of the Minneapolis VA Medical Center is to provide all levels of care; primary, secondary and tertiary; in Medicine, Surgery and Short-term Psychiatric care to eligible beneficiaries.

The 738 operating beds are designated as follows: General Medicine, 212; Coronary Care Unit, 6; Medical Intensive Care Unit, 8; Special Diagnostic Treatment Unit, 9; Renal Dialysis, 10; Satellite Dialysis, 1; Neurology, 51; Rehabilitation Medicine, 21; Total Medical beds 318. Urology, 35; General - Plastic, 40; Eye, 12; Ear, Nose and Throat (ENT), 25; Neurosurgery, 21; General Surgery, 53; Thoracic, 16; Orthopedic, 48; General - Vascular, 46; Surgical Intensive Care Unit (SICU), 13; Transplant Intensive Care Unit (TICU), 10; Total Surgical beds 319, and Psychiatry, 101.

Coordination: Advance notification of the visitation was forwarded to Mr. Daniel E. Cooney, Director, VA Medical Center, Mr. Charles W. Ferguson, Department Adjutant, Mr. Michas H. Ohnstad, Director of Rehabilitation and Mr. Glenn Neilson, Chairman, Joint Rehabilitation and Economic Subcommittee on Problems of the Aged and Aging, The American Legion, Department of Minnesota.

The entrance interview was initially conducted with Mr. Walton H. Bonner, Assistant Medical Center Director, and Mr. James L. Hinson, The American Legion Medical Center Representative. A subsequent interview, with Mr. Cooney, also included the following listed discussion topics; The Joint Commission on Accrediation of Hospitals, conducted March 15, 16, 19, 1979. Present staff levels, construction projects, security problems, nursing home care beds, equipment priorities (see attachments), regionalization, funding, closure of beds, Medical School Affiliation, space problems (non-availability of functional area), coorperation with veteran service organizations, and conversion of a U. S. Air Force Base Clinic, in Duluth, Minnesota, into a VA Outpatient Clinic.

Statistical information pertaining to patient census, personnel strength and operating beds, is attached.

Professional Affiliation: The VA Medical Center, Minneapolis, is affiliated with the University of Minnesota, Medical School of Dentistry, Medicine and Surgery. There are residency training programs in Dermotology, Internal Medicine, Cardiology, Endocrinology, Gastroenterology, Hematology, Infectious Disease, Nephrology, Psychiatry,

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Pulmonary Disease, Psychological Medicine, Nuclear Medicine, Rehabilitation Medicine, Neurology, Radiology, Surgery, Neurosurgery, Opthalmology. Orthopedic Surgery, Otoloryngology, Urology, and Dentistry. Training is provided in over 50 programs in allied health.

Special medical programs include Chemical Dependency, Epilepsy Treatment, Open Heart Surgery, Renal Transplant, Stereotaxic Surgery, and Computerized Axial Tomography.

The medical school has close ties with the Medical Center, through a Full Dean's committee. Meetings are held informally, with the basic goal of mutually supporting each facility. The affiliation, was the first between a medical school and a VA Medical Center.

Medical Center Accrediation: The Joint Commission on Accreditation of Hospitals, conducted a survey of this facility March 15, 16, 19, 1979. They granted a two year accrediation, in all areas. Their report has not yet been published, as of this survey.

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: Renovation projects are ongoing, throughout the Medical Center, to upgrade office and patient areas. Construction detracts from the facilities appearance, but will ultimately enhance the Medical Center.

The facility lies on a 100 acre tract of land, which allows adequate growth for the Medical Center and any outlying support buildings or parking. The physical structure is well kept and presents a pleasent atmosphere for patients, visitors and employees.

During the initial interview it was found that; the Medical Center Budget Allocation, for FY 79 was $67,583,000. Allocations for FY 80 are projected to be at or under the present level, which will not allow much growth.

According to management, there is a current need for 52 additional positions, (listed on statistical report, attached). During this survey, and subsequent conversations with service chiefs, it was found that; 119 positions are presently needed. The below listed specialties and numbers of positions needed, in each speciality, is over and above management figures. The additional positions would call for an increase in the personnel ceiling.

Specialty	Number of Positions (FTE)
PHYSICIANS:	
PSYCHIATRIST	1
ANESTHESIOLOGIST	1
NEUROLOGY RESIDENTS	4

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Specialty	Number of Positions (FTE)
NURSING:	
REGISTERED NURSES	40
SOCIAL WORKERS:	
M. S. W.	1
GRECC STAFF	20
SURVEY TOTAL	67
MANAGEMENT TOTAL (listed on Statistical Sheet)	52
COMBINED TOTAL	119

The implementation of Intravenous Additives and Unit Dosage, throughout the facility, is estimated by FY 85. This program will bring an additional need for 20 Pharmacists.

The average cost per patient day in the Medical Center, Outpatient visits and community Nursing Homes, have increased over the past two years. Their costs are projected to climb even higher during 1980. (See statistical sheet - funds)

The Director indicated there were plans to build a 120 bed Nursing Home Care Unit (NHCU), which would be attached to the construction of a purposed New Medical Center. He also stated a future need for an additional 208 bed Domiciliary Unit within Medical District 18. The most accommodating location would be in St. Cloud, Minnesota.

The non-availability of functional area was described to be very much of a problem throughout the medical center. Problems exist in Building 3, i.e. no patient privacy, inadequate work and/or patient area, and limited sink and toilet facilities. S.I.C.U., T.I.C.U. and Recovery, have crowded conditions, with little working area for nursing personnel. Other areas, such as, Rehabilitation Medicine, Pharmacy, and Nursing, Neurology, Psychiatry, and the Geriatric Research, Education and Clinical Center (GRECC) unit, have all expressed concern about functional area.

The Director stated that the relationship between The American Legion and the Medical Center was, and had been from the inception of the Medical Center, working very well together. An open door policy has been taken by both agencies, allowing for more communication and support between them.

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The subject of the VA incorporating the U.S.A.F. Clinic in Duluth was discussed. Mr. Cooney. indicated there was a need for a VA Outpatient Clinic in that area. But, the only way his Medical Center could incorporate and operate the facility adequately, would be with additional personnel, funding and long range plans to upgrade the present clinic.

Assistant Director, VA Medical Center indicated Building 7, a 64 bed unit, was closed during February, 1979. Patients and staff were brought into the main building. This move provided additional coverage, at ward level, by the 32 staff members and provided better care for the patients. No patient or service was dropped, due to the closure. Primary reasons for closure were; staffing levels, conditions and location of Building 7 in relationship to the Medical Center and category of patients.

He also stated, major problems which concerned him were, decreased funding for FY 80, recruitment of professional personnel and staff shortages.

This Medical Center, was approved for a 120 bed Nursing Home Care Unit (NHCU) 2 years ago. The delay in its construction is due to major defficiencies within the Medical Center, which must be corrected first.

No major security problems have occured on this station. Management is recruiting for two additional security persons at present, which will increase their force up to ten personnel.

Professional Services: The acting Chief of Staff stated, the major problems within his area of responsibility were; the non-availability of functional area, monetary gains and rewards for the retention of professionally trained Physicians and Nurses.

He realized, management was doing its utmost to provide additional work and patient area. The basic problems according to him, lies in the need to lift the salary caps which does not allow for Physicians to stay monetarily close to the private sector.

The C.O.S. stated the Medical Affiliation with the Minnesota School of Medicine was very strong, with ongoing mutual support. He and the Medical Center Director are presently on the Dean's Committee. Major Service Chiefs do attend, but do not have voting privileges.

He indicated there is a need, in Duluth, for a VA Outpatient Clinic. However, VA Medical Center Minneapolis, currently does not have the additional resources to provide staff or support for such a clinic. The final decision, concerning appropriation of funds and staff must first come from VA Central Office.

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REGIONALIZATION

Medical District 18 is comprised of Fargo, North Dakota; Sioux Falls, South Dakota; St. Cloud, Minnesota; and Minneapolis, Minnesota. The District coordinator is Mr. Cooney, Director of VAMC Minneapolis. District meetings are held quarterly or as needed, to share information and resolve problems. Regionalization has been well received, within District 18. It was described as being very beneficial and promotes sharing between Medical Centers.

Attached is Medical District 18's Master Priority Listings.

ORIENTATION/PREPERATION OF INCOMING PERSONNEL

Material, concerning employee rights, privileges and opportunities, is provided to all personnel, during the initial phase of employment. This material, also indicates departmental activities, history of the Medical Center and the VA's role in providing health care to the nation's veterans.

OUTPATIENT/ADMISSIONS AND AMBULATORY CARE SERVICE

The service chief indicated his service, "provides a service to those who need it." He was very emphatic about the distinction between Service and Non-Service Connected veterans. Staff on his service, have been made aware of all regulations concerning S.C. priorities. But he indicated, no veteran will ever have an excessive waiting time.

Medical residents are responsible for seeing the majority of patients. All residents are under the close supervision of a Licensed Physician.

An eventual problem lies in the number of patients budgeted for verses patients seen. At present his service is budgeted for 25,000 outpatient visits. This is far below the number anticipated to be seen, next fiscal year.

The Chief is in favor of an outpatient clinic located in Duluth. This facility would possibly decrease outpatient visits to VAMC Minneapolis. It would decrease travel pay, presently being paid for the 162 miles to Duluth. His reservations are in the area of staffing and funding for a fully qualified outpatient clinic.

MEDICAL ADMINISTRATION SERVICE

Statistics concerning the bed occupancy rate as of FY 79, cumulative through June 30, are as follows:

VETERANS ADMINISTRATION MEDICAL CENTER
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MEDICAL	73%
SURGICAL	73%
PSYCHIATRIC	90%
NEUROLOGY	85%
REHAB. MED.	96%
TOTAL	80%

The breakdown of In-house patients on August 7, 1979 were as follows:

SERVICE	SERVICE CONNECTED	NON SERVICE CONNECTED	PATIENTS
Medical	71	133	204
Surgical	81	151	232
Psychiatric	32	58	90
Neurological	15	28	43
RMS	7	13	20
	206	383	589

VA Form 10-10 (Applications for Medical Care), which have been received to date, number 26,468. Of these, 23,786 have been excepted and 2,497 have been determined, not to need medical care.

A review of application requests for Disability Evaluation Examinations (2507), indicated there were 388 pending. The reasons were, the veterans have been scheduled and will be coming in within 30 days. The second group was waiting dictation and signatures on examinations. The final catagory were having examinations rescheduled at veterans request. The oldest 2507 was dated May 10, 1979, and was waiting for physician signature.

There were 20 summaries pending, at the time of this visit. The reasons being, they are death cases awaiting cause of death from Pathology.

Presently, there are 113 Service Connected scheduled admissions between the months of August 1, 1979 until November 30, 1979. A total of 252 Non-Service Connected admissions are scheduled for the same time period. These were listed as veterans who were to have elective surgery.

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An admission time study, was conducted during a two-day period of March 19-20, 1979. A total of 237 patients were involved. The study indicated, various lenths of time a patient would require at any one area during the admission process, as an unscheduled patient. Findings show; admitted patients who were unscheduled during regular work hours (8:00 a.m. to 4:30 p.m.) could expect the processing time to be 118.2 minutes. Those patient's who were seen during irregular hours (4:30 p.m. to 8:00 a.m.) could expect a processing time of 110.1 minutes. This was a decrease of 20.8 minutes from the last time survey for patients who were classified as unscheduled and seen during, regular hours.

A comparison of total time was done for service-connected and non-service-connected patients. This time was 103.1 (SC) and 117.0 (NSC), averaging a difference of 14.1 minutes. This would indicate a definite effort is being made to expedite the applicants who are service connected, in all stages of the admissions process.

BED SERVICE

Medical Service is authorized 246 beds with 200 veterans presently occupying beds. The Chief, expressed concern about the possibility of losing up to 80 percent of the physicians due to inadequate pay scales and limited advances over the past years.

Physician's who work for the Veterans Administration, are no longer competitive with th[illegible]ivate community. Until salaries and working conditions are upgraded and brought into line with the rest of society, the VA will be just a training ground for the community Medical Centers.

He indicated the main reason staff members do stay, is because of the research and teaching, presently untaken by this VA Medical Center.

Surgical Service is authorized 319 beds. Presently, there are 222 veterans on the service. His major problems are in support services i.e. nursing. The retention and salary for qualified nursing personnel was quoted as being the leading factors.

He also indicated, Building 3 was not structurally adequate for patients to be housed i.e. there is no patient privacy and very limited washrooms for patients or staff.

The Assistant Director indicated, the Urology Building was being upgraded but would still not meet the proper standards.

Psychiatry is authorized 101 beds and presently has 90 veteran patients.

The acting Chief of Service stated there were two predominant age groups being treated. Those were, 20-30 year olds and the 45 plus age group.

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He also indicated his service had problems with the non-availability of functional area. The greatest area needs were with office space and interviewing rooms.

Drug Dependency Treatment Program (DDTP): As stated by the spokesman for DDTP, "We do not make a distinction between substances abuse, i.e. Alcohol or Drug. The term, drug, is used synonymously with alcohol. Drug Dependency is used synonymously with the term, chemical dependency, and includes the terms: Alcoholism, Drug Addiction, Drug Habitutation, and Alcohol Dependence." This DDT program is eleven years old with a total of 6000 veterans who have received help from the unit. Half of the admissions were said to be by referrals from graduates of this program.

The department organizational staffing chart shows four program components. First the office of the chief. This office is comprised of one Chief DDTP (Physician), one Program Coordinator (Social Worker) and a Secretary. They provide program planning, goals, services direction, coordination and evaluation of the Drug Dependecy Treatment Program in accordance with VA regulations.

Second, the area of Outreach and Intake. The section has one Intake Counselor, one Community Services Specialist, one Veterans Outreach Counselor, and one Veterans Assistant Counselor. This area of treatment, reaches into the community systematically to identify veterans who are experiencing problems with drug/alcohol use, and provides assessment and assistance to veterans to enter and accept appropriate available services.

The basic required program, a veteran will receive while as an inpatient is; Lectures, Group Therapy, Recovery Group, Physical Exercise, Reading Groups, Community Recovery Self Help Groups, Alcoholic Anonymous, Individual Counseling, and Alumni Night meetings.

There are also basic required family programs such as; Concerned Persons Workshop, Concerned Persons Group, Alanon, Partners Groups, and Family Conferences.

The third area provides care for Inpatient/Aftercare patients. The inpatient program has 41 beds. The length of the program is 30 days, with the average daily census of 38.4 days. The percent of utilization was placed at 94 percent. It is comprised of one Physician, one Chaplain, one Supervisory Social Worker (Program Coordinator), two Social Workers, one Clinical Psychologist, one chief Counselor, four Chemical Dependency Couselors. one Head Nurse, seven Registered Nurses, one Licensed Practical Nurse, and two Nursing Assistants. They provide, multimodel treatment and education services to assist veterans in recognition of their loss of personal freedom and acceptance of their chemical dependency; in regaining their lives (self-honesty) and in engagement in the recovery self help social support system and non-chemical alternatives for living.

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The final area of care, provided for is Outpatient/Methadone. This area is staffed with one Physician (Chief), one Social Worker, one Chemical Dependency Counselor, one Licensed Practical Nurse and one Secretary. This unit provides drug evaluation, counseling and education, methadone treatment (stabilization and detoxification) relationship counseling, vocational rehabilitation and mental and phsysical health services.

This area of treatment (methadone) has been in operation for eight years, with 2530 veterans presently on the roles.

This unit, has at its disposal within the state, 44 prevention centers, 114 information and referral centers, 29 receiving centers, 17 outpatient clinics, 34 primary treatment centers, 19 extended rehabilitation centers, 47 halfway houses, 19 Native American and 48 Driving While Intoxicated (D.W.I.) clinic programs. The treatment and rehabilitation capacity of these private and public programs can provide services to 20,523 individuals at one time.

Neurology has 51 operational beds with a present census of 40 veterans. The chief stated his service was presently understaffed in the area of residents and nursing.

He also indicated a growing need, throughout the VA system, for increased support and research for older veterans. This need arises because of the increasing age and higher possibility of strokes with the increased age. These supports could be in the areas of Geriatric Research, Education and Clinical Centers (GRECC's) and/or long term rehabilitation housing i.e. Nursing Home Care Units, Domiciliaries, Halfway Houses, Geriatric Day Care or Congregate Housing.

Rehabilitation Medicine, presently is authorized 21 beds. All are filled at this time.

The Chief expressed a need for the upgrading of salary, which would stay in line with the regional cost of living.

There is also a need for additional functional area, i.e. examination, conference and office areas.

ANCILLARY SERVICES

Radiology, is presently undergoing a massive reconstruction project, which will add more area for equipment and patients. This service is divided into two areas; one diagnostic, located on the second floor of Building 43, the second being therapeutic, located in Building 18.

The service chief expressed, two areas of concern: first, the freeze on salary caps, second, the elimination of training funds for radiology technicians.

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This surveyor, was informed about the concern over alleviation of training funds, which had been approperated by V.A.C.O., for an on going Radiology Technician Training Course on station. Management has considered this program too valuable to drop. Therefore, the Medical Center has appropriated funds to continue the program. A major question was posed, as to why a valuable training course would be dropped by VA Central Office, during a time when Radiology technicians were in short supply?

Social Work Service: The Chief indicated there 65 community Nursing Home Care facilities which are under contract to provide services to 160 veterans. The average daily cost is $33.39 per patient per day. The maxium cost presently allowed is $46.50 per veteran per day.

He also stated, a study had been conducted to determine a need for an Outpatient Clinic in the Duluth area. This study also indicated the number of veterans who would benefit from such a clinic. This report, dated in 1975, indicated there were 31,377 veterans in or near the city of Duluth. Present statistics (1979) show, within a Seventeen County area of Duluth, (Northern Minnesota) there are 67,629 veterans. An additional 45 to 50 thousand veterans could be served from Northern Wisconsin and the upper peninsula of Michigan.

Nursing Service: As indicated by the Chief of service, there is a critical need for additional staff ceilings, which would allow for adequate staffing. Another concern is the salary cap, which does not allow nursing professionals to be paid in line with local professionals.

The Chief stated this facility is like many Medical Centers, in that the recruitment is limited even with an adequate supply of nursing professionals in the area. The turn-over rate was stated to be 30 percent during the last year.

Mention was also made concerning the non-availability of functional area. Units such as S.I.C.U., T.I.C.U. and Urology were considered to be most limited in patient care and work area.

Overtime, during the past eight months has increased because of low staffing. Statistics show the equivalent of an additional 7 to 15 F.T.E. hours of overtime being paid per 40 hour week. This does not include surgery.

Nursing personnel are having to perform, non-nursing functions between the hours of 4:30 p.m. and 8:00 a.m., due to the limited number of maintenance and clerical staff.

Pharmacy Service, has its main location in Building 1, with two smaller locations in Building 6 and the Outpatient unit. The Building 6 unit, is the only area in the Medical Center presently using Unit Dosage.

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Total Intravenous Additives and Unit Dosage programs are projected for FY 85. These programs will need an additional 20 personnel. At that time, the pharmacy will be open and staffed 24 hours per day, seven days a week.

Functional work and storage area is critical in all three locations.

Turnaround time, for mailout prescriptions and supplies, was placed at two days. Waiting time for prescriptions, within the Medical Center, was excellent. Service connected veterans wait between 20 to 60 minutes, while non-service connected hold from 40 to 90 minutes.

Veterans Administration Voluntary Services (VAVS): The American Legion, VAVS Representativeis Harry Parsons, his Deputy is Lloyd Home. The American Legion Auxiliaries, VAVS Representative is Alice Roulet. Her Deputies are Verna VanDerbeck, Billy May Lindgren, Treasa Coppel and the Associate Deputy representative in Wisconsin is Bula Hanvelt.

This facility has 35 organizations, who volunteer time and energy. The Amercian Legion has contributed, as of January 1, 1979 until July 31, 1979, 228 regularly scheduled volunteers on a monthly average who have provided 2196 hours. The American Legion Auxiliary contributed 87 regularly scheduled average monthly volunteers who provided 1000 hours.

The American Legion, Operation Post Home volunteers, provide veterans a wide variety of activities off the Medical Center grounds, and not limited to ill veterans. The Gopher Post #74 is located at 3418 East Lake St., Minneapolis, MN.

Gopher Post Home activities are open to any veteran within the community. Activities presently undertaken are: congerate meals, outings to sporting events, cultural events, a wide variety of public speakers and other events.

The Gopher Post Home has volunteered man hours since October 1, 1978. From the 12 volunteers, there have been 447 visits which has resulted in 2,840 total hours.

Geriatric Research, Education and Clinical Center (GRECC): The Chief expressed a critical need for an additional twenty persons, research laboratories and a ten bed Geriatric Diagnosis and Demonstration Unit, which had been authorized at the inception of the program. At present, he has eight staff persons and office space.

He indicated the principle behind the GRECC's are to research and educate using a clinical setting for demonstration of the theory. All three are separate, but essential sub-units of the total arena of aging.

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If the major problem facing the GRECC, i.e. staff, laboratory and diagnostic unit, are not solved he indicated the program would no longer be functional as a service to the elderly. The limited function could cause stagnation and possibly the demise of the program.

III. CONCLUSIONS

It is concluded, the quality and quantity of services presently given is adequate, within the present constraints of staffing and non-availability of functional area.

During the survey of this Medical Center, it was obvious, that even with the construction projects presently underway, there will be a storage and functional area shortage. Management stated, there were plans to build a new facility. This would alleviate many of the space problems and add needed clinical areas for the GRECC unit.

This surveyor found the major problem areas, within this Medical Center to be; A) Salary caps for Medical Center employees. As mentioned by various professionals, the salary difference between the Veterans Administration and the private sector is quite large. B) the contemplation of many professionals i.e. Physicians, Nurses and Technicians, to terminate employement because of low salaries. Many service chiefs indicated a large number of professionals were taking a "wait and see" attitude about salaries, before acting. C) Non-availability of functional area has caused many services to crowd workers, patients or equipment together. Crowding is not good for moral or safety i.e. safety standards. D) Staffing, especially in Nursing, Neurology, Pharmacy and the GRECC services were critical. Limited personnel in these areas do not provide the optimum care the veteran deserves. E) The elimination of Radiology technicians education funds by V.A.C.O., was found not to be in the Medical Centers and most of all the veterans best interest. To keep the program functioning, funds had to be channeled from other areas to cover what had been withdrawn. F) The GRECC unit, is in desperate need of additional staffing, and area. The field of Aging is the fastest growing area of concern within the country. While the VA is dealing with the aging veterans population presently, our society will have to deal with the massive aging population within the next 25 years. Therefore the veterans Administration will be the forerunner in this field.

IV. RECOMMENDATIONS

1. It is strongly recommended that the Administrator of Veterans Affairs and the Chief Medical Director support legislation for increased salaries for physicians, dentists, nurses and technicians and other VAMC employees.

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2. It is recommended that the Administrator of Veterans Affairs and the Chief Medical Director support legislation to construct a replacement Medical Center at VAMC Minneapolis, Minnesota.

3. It is recommended that the Chief Medical Director provide funding for additional staffing for the various Medical Center Services mentioned in the body of this report allowing optimum coverage and care within the Medical Center.

4. It is recommended that the Chief Medical Director reestablish funds for radiology technician education courses at this Medical Center.

5. It is strongly recommended that the Chief Medical Director authorize proper funding so that approved staff levels are met; office area and clinical laboratories be provided for, to allow the Geriatric Research, Educational and Clinical Center to operate at an optimum level.

6. It is recommended that the Administrator of Veterans Affairs authorize a needs study of the U. S. Air Forece Base Clinic, Duluth, Minnesota for the purpose of converting it to a VA Outpatient Clinic. If the study indicates the need for an Outpatient clinic in the Duluth area, then approval must be given.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

Date of Information July 1979

Location Minneapolis, Minnesota

Act. Chief of Staff Robert A. Petzel, M.D.

Hospital Director Daniel R. Cooney

Assistant Hospital Director W. H. Bonner

Medical School Affilitation University of Minnesota

	Current FY 1979	Last FY 1978
Bed Capacity	738	862
Operating Beds	738	862
Average Daily Inpatient Census	589	620
Outpatient Census	149,499 (thru 6/30)	205,021

Waiting List:

Service Connected --

Nonservice-Connected --

Explain the Reason for the Waiting List:

VA Form 10-10 Applications for Medical Care

Received last Fiscal Year 36,685

Number of Applications Accepted 35,066

Number of Applications Rejected 1,052

Applications for Medical Care Received this Fiscal Year 26,468

Number of Applications Accepted 23,786

Number of Applications Rejected 2,497

Staff

Total Hospital Personnel(FTE) 1935.9

Core Ratio 1.88

Staff Physicians(FTE) 130.6

Consultants on the rolls }
Attendings on the rolls } 235

Residents 208

Medical Students 54

Physician Extenders --

Major Personnel Shortages

Physicians (FT by Specialty)

Psychiatrist 1

Anesthesiologist 1

Registered Nurses 20

Licensed Practical Nurses 6

Nursing Assistants 4

Others Radiologic Techs 2

Clerk-typists 15

Medical aids 3

Scheduled for Admission (Service-Connected) August - November 113 (31%)

Scheduled for Admission (NonService-Connected) August - November 252 (69%)

UNDICATATED Summaries Pending 20

Total number of requests for Disability Evaluation Examinations (2507) on hand which have not been completed and returned to VA Regional Office 388

Operatings Beds in Nursing Home Care Units None

Funds	FY 1978	FY 1979 (10/1/78-3/31/79)
Average Cost per Patient Day	$186.98	$197.19
Average Cost per Outpatient Visit	$62.44	$70.20
Average Cost per NHCU Day	N/A	N/A
Average Cost per Patient Day in Community Nursing Homes	$29.01	$33.39
Hospital Budget Allocation (This Fiscal Year)		$67,583,000
Hospital Budget Allocation (Last Fiscal Year)	$63,097,000	

(Revised January 1, 1979)

LISTING OF NRM&R PROJECTS FOR FY-78

		Funded	Unfunded
78-001	Energy Conservation Study	$ 28,000	
78-002	Repl Hot Water Tank	20,000	
78-003	Repl Doors	131,000	
78-004	Survey A/C, Heating Controls	3,780	
78-005	GRECC Staf. Offices	26,000	
78-007	Remdl for Radiology Room 219	15,300	
78-008	Relocate Occupational Therapy	98,000	
78-011	Repl Corridor Tile, Bldg. 43	64,000	
78-012	Install Elevator, Bldg. 61	57,200	
78-013	Increase Capacity Chem Lab, Bldg. 1	23.500	
78-014	Seal Roads and Lots	20,300	
78-015	Re-Key Hospital	46,700	
78-016	Repl Storm Windows	32,900	
78-101	District Energy Conservation System	189,000	
78-102	Extend Electrical Circuits	93,223	
78-103	Repl Galvanized Drain Lines	29,403	
78-105	Extend Emergency Elec. Svc, B.43,5,6,7	40,285	
78-106	Update Nurses Call System	152,427	
78-108	Repl Generator (100KW w/400KW), Bldg.1	375,000	
78-109	Repl Generator, Bldg. 49	175,000	
78-110	Remdl Dental Clinic, Bldg. 43	57,528	
78-112	Repl Ceiling Tile, Bldg. 43	59,629	
78-113	Install Floor Covering - Connect Corridor	13,302	
78-701	Install Automatic Door, Bldg. 51	4,252	
78-702	Install Automatic Door, Bldg. 5	1,947	
78-801	Remdl Library, Bldg. 43	134,500	

LISTING OF NRM&R PROJECTS FOR FY-79

79-001	Canteen Vending Room	16,100	
79-002	Repl Telephone System	38,100	
79-003	Insulate Attics	36,000	
79-004	Insulate Attics	36,000	
79-005	Remdl Radiology Room A216, Bldg. 43	17,000	
79-006	Remdl Radiology Room 146, Bldg. 6	11,000	
79-007	Remdl for GRECC	28,000	
79-009	Remdl Lav for Handicapped	32,000	
79-010	SDTU	45,000	
79-101	Repl Doors w/Fire Rated Type	262,300	
79-104	Relocate Biomedical to Bldg. 61		80,800
79-105	Seal Roads & Parking Lots	31,000	
79-106	Alter for Coagulation Lab, Bldg. 1	31,300	
79-107	Add'n Automatic Fire Sprinklers		155,500
79-108	Correct Fire and Smoke Hazards	44,300	
79-110	Improve Fire Safety of Buildings	50,000	
79-112	Pave Roads and Parking Lots	64,300	
79-113	Alter Bacteriology Lab, Bldg. 1	73,100	
79-114	Seal Holes in Corridor Walls	49,800	

Listing of NRM&R Projects for FY-79 Continued

		Funded	Unfunded
79-115	Alter Transplant ICU, Bldg. 43	$105,300	
79-116	Geriatric Day Trtmt Ctr., Bldg.210		$ 72,400
79-118	Modify Dumbwaiters, Bldg. 41		54,900
80-122	Remdl Bldg. 48 for Shops	15,340	
80-123	Corridor Ceiling, B.1 to B.2	20,564	
80-124	Fire Station	58,000	
80-125	Remdl Personnel Service		38,000
80-801	Install Lavatories, Bldg. 9		57,000
80-901	Remdl Research Labs, Bldg. 41		61,000

LISTING OF NRM&R PROJECTS FOR FY-80

80-101	Linen Chute(s) Revision	24,000	
80-102	Remdl Lavatories	69,800	
80-103	Hand Rails, Bldg. 43	42,000	
80-104	Replace Walk-In Freezer, Bakery	58,000	
80-105	Loading Dock Improvement, Bldg. 43	12,000	
80-106	Repl Corridor Ceiling, Bldg. 1	64,000	
80-107	Repl Floor Covering	49,000	
80-109	Repl Valves, Water Lines		55,000
80-110	Add'l Circuit Breaker Assembly	45,000	
80-111	Repl Galvanized Drain Line	50,000	
80-112	Repl Fire Hydrant and Valves		20,000
80-113	Alter Control & A/C - SICU/CCU		21,000
80-115	Repl Corridor Windows	64,000	
80-116	Repl Thermal Controls, Bldg. 1		49,000
80-118	Repl Equip Ground Controls		14,000
80-119	Repl Medical Gas Units		47,000
80-120	Repl Diseased Elm Trees		20,000
80-121	Repl Gas Distribution, Ft. Snelling		124,000

LIST OF CONSTRUCTION PROJECTS

	Funded	Unfunded
Major & Minor Construction Submission - FY-78		
Clinic Addition to Bldg. 43		$17,624,750
New Pharmacy Bldg.		973,669
Second Floor, Bldg. 54		435,000
So. Addition to Bldg. 49		992,700
Addition to Research, Bldg. 17		592,625
New Fire Station		614,700
Minor Miscellaneous - FY-79		
Replace Modular Building		181,000
Remodel Nursing Stations, B.1,5,7 & 43		396,394
Expand Medical Gas Svc.,Bldgs. 1 and 43		446,159
Major & Minor Construction Submission - FY-79		
Medical Facilities Improvement		21,123,750
Supply Office & Warehouse		2,150,000
Minor Miscellaneous - FY-80		
Remodel SPD, Bldg. 43	$ 405,200	
Remdl Nurses Stations, Bldg. 43		207,555
Remdl Nurses Stations, Bldg. 1		229,266
Major & Minor Construction Submission - FY-80		
Supply Office & Warehouse		2,171,375
Central Air Conditioning		29,589,000
Addition to Research, Bldg. 49		770,370
Deadend Corridor Stairs ($1,760,900 available)		
Replace Fire Alarm System (Completed FY-78)	357,065	
Expand Diagnostic Radiology, Bldg. 43 (To be completed FY-79)	801,000	
New Boiler Plant ($5,307,000 available)		
Addn. for Cl. Support, Ambulatory Care, Outpatient (A/E developing conceptual design. - $6,666,000)		

MEDICAL DISTRICT #18

MASTER PRIORITY LISTING

UNFUNDED EQUIPMENT, EXPENDABLE NEEDS, EXCEEDING $150,000

DISTRICT PRIORITY NUMBER	ITEM	COST	MC
~~1~~	~~Special Procedures Room~~	~~$753,597~~	~~Fargo~~
2	Replace Monitoring Equipment in Medical Intensive Care Unit and Coronary Care Unit	$271,860	Minneapolis
3	Pho/Gamma LEM Scintillation Camera System	$158,000	Minneapolis
4	X-ray apparatus, Verseograph System for Tomography	$150,000	Minneapolis

MINNEAPOLIS VA MEDICAL CENTER

UNFUNDED EQUIPMENT, EXPENDABLE NEEDS LESS THAN $150,000

PRIORITY NUMBER	ITEM	ADD'L (.025) REPLACEMENT (.019) EXPENDABLE (.001)	COST	M&R COST	SERVICE
1.	Ultra-sound Equipment	(.025)	$110,000		Med. Service
2.	Multistat Analyzer	(.025)	40,000		Lab. Service
3.	Word Processor	(.025)	12,000		MAS
4.	Liquid Chromatograph	(.025)	24,350		Med. Service
5.	Gas Liquid Chromatograph	(.025)	15,305		Med. Service
6.	Storage Cabinets & Work Tables on Rails	(.025)	19,000		Diag. Rad.
7.	Motorized X-ray Viewer	(.025)	15,500		Diag. Rad.
8.	Sorvall Centrifuge	(.019)	13,300		Lab. Service
9.	Ear Oximeter	(.025)	9,395		Med. Service
10.	Blood Processor	(.025)	18,500		Lab. Service
11.	Auto Sample Processor	(.019)	9,000		Lab. Service
12.	Dade Auto Phy	(.019)	20,000		Lab. Service
13.	Freezer, Ultra Low (2)	(.025)	12,000		Lab. Service
14.	Photomicroscope	(.025)	15,000		Lab. Service
15.	Color Studio Camera for Endoscopy	(.025)	12,000		Surgical Svc

FOUNDATION FOR HEALTH CARE EVALUATION
20 Washington Avenue South, Suite 400
Minneapolis, Minnesota 55401
Telephone • Area Code (612) 340-8600

April 4, 1980

The Honorable Alan Cranston, Chairman
Senate Committee on Veterans' Affairs
410 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Cranston:

The Foundation for Health Care Evaluation, a non-profit corporation with headquarters in Minneapolis, has followed with interest the published account of plans to construct a new Veterans Administration Hospital in the Twin Cities. Functioning as a peer review body and representing more than 2600 practicing physicians, the Foundation has identified several items of concern which relate to the Veterans Administration's rebuilding plans.

Before discussing those concerns, it should be very clear that the Veterans Administration Hospital is recognized and respected for its service to the area as well as for its teaching and research activity. The concern relates to differing standards which exist by virtue of governmental regulations mandated for all other area hospitals but which do not apply to the Veterans Hospital.

At the present time the Twin Cities area is considered to have an excess of acute care beds. This assessment has been made by the Metropolitan Health Board, an arm of the Metropolitan Council, which serves as the Health Systems Agency (HSA). In its role the HSA reviews the community needs and has the authority to approve or disapprove all hospital building or expansion of facilities. Several requests for construction projects have been denied under this process. This federal program, however, does not reach to the Veterans Administration hospitals with the same authority it has been given to regulate all other hospitals. The A-95 Review which applies to the Veterans Administration Hospital is merely advisory in nature. It is our belief that the Certificate of Need process should be applicable to the Veterans Administration in the same fashion and that the benefits would be felt by the entire community.

It is important for the government to appreciate, from its side, the impact a decision to proceed with the reconstruction of the Veterans Administration Hospital has, here, on the efforts other agencies are making to get this community to deal firmly with the need to reduce the size of its own hospital system. Currently, a number of questions have been raised about the relationship of this Veterans Administration hospital to the community system. One, of particular significance, is its relationship to the proposal (proceeding concurrently) by the University of Minnesota for a $200 million reconstruction of University Hospitals, with which we know the Veterans Administration Hospital is closely affiliated, as a part of the teaching-hospital system. The immediate question seems to be: Can decisions about the proposed Veterans Administration in Minneapolis be suspended until there has been an examination of its impact upon, and possible relationship with, the hospital system of this community?

The Board of Directors of the Foundation for Health Care Evaluation is calling these issues to your attention in the hope that you will do whatever you can to help bring about equity in the Certificate of Need process. We thank you for your attention.

Sincerely yours,

Carl G Gustafson

Carl G. Gustafson
Executive Vice President

CGG:clg

WEST METRO HOSPITAL TRUSTEE COUNCIL

April 15, 1980

Mr. Jonathan Steinberg
Chief Counsel
Senate Committee on Veteran Affairs
410 Russell Senate Office Building
Washington, DC 20510

Dear Mr. Steinberg:

The West Metropolitan Trustee Council which I was representing on Tuesday, April 8th, represents the major hospitals or hospital systems in the Greater Minneapolis area. In forming the council, its composition was limited to the voluntary leaderships...trustees and in most every case, the President and Chairman of the Board of the hospitals represented. The council was formed in the belief that voluntary solutions to complex social and economic issues are normally preferable and more efficient than externally imposed solutions.

The Trustee Council held over 50 meetings between the months of April and October 31, 1978, during which time we studied the available materials, listened to the experts, discussed and debated the issues, and finally, on October 31, 1978, issued to the Health Board and community at large our recommended changes for the Metropolitan Health Care System. We called it The Voluntary Sector's Approach...and that is precisely what it was.

Working in conjunction with the Health Board and others (and perhaps as a surprise to both them and the community) our final report made some dramatic recommendations. When we began our deliberations, we faced a relatively hostile Health Board which was firmly convinced that the only solution to the problem was a precipitous and dramatic one, involving the closing down of certain hospitals. By virtue of our efforts, we were able to convince the Health Board that these recommendations should be adopted and an overall plan of cooperation between virtually all segments of the private and public health delivery sector developed between the Health Board.

Page 44 of the West Metro Hospital Trustee Council's "Recommended Changes in the West Metro Health Care System" addressed the Federal VA Hospitals. The findings, conclusions and recommendations are attached. Essentially, the Trustee leadership of the community is saying that the certificate of need process, the long range plan review, and voluntary bed reduction need to be coordinated throughout the community as to eliminate conflicting trends and promote the total health delivery system that delivers quality care at the most reasonable cost.

Thank you for the opportunity of submitting the West Metro Hospital Trustee Council's position with regard to the proposed new Veteran's Administration Hospital.

Very truly yours,

S. Albert D. Hanser
Vice Chairman, West Metro Hospital Trustee Council
Chairman, Public Policy Task Force

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Enclosure

RECOMMENDED CHANGES IN THE

WEST METROPOLITAN HEALTH CARE SYSTEM

The Voluntary Sector's Approach

FEDERAL V.A. HOSPITALS

Findings

1. The federal V.A. hospitals currently are not included in the local community long-range planning process.

2. There are conflicting trends currently at work; to reconstruct the federal Veterans Administration Hospital System at the same time the private hospital system is being decreased and constrained.

Conclusions

1. Effective planning cannot be achieved unless the activities of all hospital providers are taken into account. For this to occur, all acute-care providers must be willing to participate in the planning process.

2. Some of the services provided in the federal veterans hospital system are identical to those provided in the private hospital system. The degree of duplication and overlap and the potential for purchase of service or sharing arrangements has not been ascertained due to regulatory constraints.

3. The recommendations in our current report are constrained by the lack of specific detailed information on the short and long range plans of the federal veterans hospital system.

RECOMMENDATIONS

1. All hospitals funded by the federal government should be included under certificate of need, quality assurance, utilization review, regulation and the ongoing long-range planning process. Even more important, however, is the need for regular informal communication between all public and private hospitals in order to provide better health care at a more reasonable cost.

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CABLE ADDRESS
OBO

May 6, 1980

Ms. Janice Orr
Assistant to The Honorable Alan Cranston
Senate Committee on Veterans' Affairs
410 Russell Senate Office Building
Washington, D.C. 20510

Dear Ms. Orr:

As the Chairman of the East Metro Hospitals Council, I wanted to bring to your attention our concern regarding the construction of a new Veterans Hospital in the Twin Cities area.

The East Metropolitan Trustees Council feels that construction of a new Veterans Hospital in the Twin Cities area is a matter of considerable concern. Replacement of a major unit in the metropolitan area at a time when there is general agreement that the other hospitals have an excess number of beds requires careful review before final plans are made for new buildings.

We appreciate the willingness of the Veterans Administration to submit its plans to the Metropolitan Health Board for review and hope it will result in coordination of care for all metropolitan area patients. We recognize that while some Veterans Administration patients could appropriately be cared for in other hospitals, there are also some types of cases those hospitals might prefer not to handle.

However, we think that if another Veterans Hospital is needed, care should be exercised to avoid construction of duplicative facilities and to arrive at maximum benefits from the longstanding association with the University of Minnesota Hospitals.

Could not some savings be realized by sharing of services between the Veterans Hospital and the University of Minnesota which is also considering a new facility? The close teaching relationship between the two institutions would seem to offer special opportunities for both of them.

Ms. Janice Orr
Page Two
May 6, 1980

For example, why not consider an "H" shaped facility with each leg housing beds for the two institutions and a connecting unit for offices, classrooms, laboratories, radiology and other supporting services common to both. Such an arrangement ought to save time and money in travel and communication expenses as well.

We also wonder if it is appropriate that the Veterans Hospital for the first time build and operate their own long term care facility in an area such as the Twin Cities when veterans long term care needs could be adequately well served by the existing system.

As the Veterans Administration is a major provider of services to metropolitan area residents, we would also like to have its long range plan submitted periodically to the local HSA as is done by other hospitals in the area.

We applaud the efforts made to date toward finding a less expensive approach and urge further such efforts. If we can be of any help, please feel free to call upon us.

Very truly yours,

JT O'Neill

Joseph T. O'Neill, Chairman
East Metro Hospitals Council

JTO:ame

cc: Mr. Roger Starn